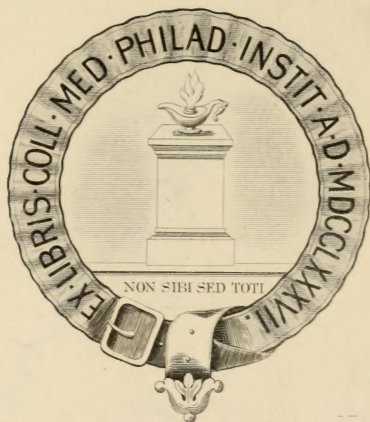




61340




Class _____ No. _____

Presented by

H. A. Hare, M.D.

3.50



Digitized by the Internet Archive
in 2013

The

HAHNEMANNIAN

Monthly.

(VOLUME THIRTY-SIXTH.)

JANUARY TO DECEMBER,
1901.

EDITED BY

CLARENCE BARTLETT, M.D.

WITH THE COLLABORATION OF

WM. B. VAN LENNEP, A.M., M.D.

WM. H. BIGLER, A.M., M.D.

WM. C. GOODNC, M.D.

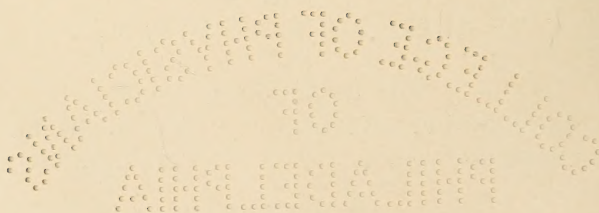
CHAS. M. THOMAS, M.D.

PHILADELPHIA:

1901.

MAR 24 1902

Copyrighted, 1901,
By CLARENCE BARTLETT, M.D.



THE HAHNEMANNIAN MONTHLY.

JANUARY, 1901.

THE GASTRIC NEUROSES.

BY WM. C. GOODNO, M.D., PHILADELPHIA.

EVEN our special treatises give insufficient attention to the neuroses of the stomach, if one may judge from the frequency of stomach disorders of this class as compared with other stomach affections. We meet troublesome so-called functional disorder of this organ much more often than organic disease. As, in some cases of functional disorder of the stomach, serious organic change is the terminal event (ulcer, for instance), it is hardly possible to draw a hard and fast line of demarcation between functional and organic disease of this organ as viewed from the clinical standpoint. The intractable character of some stomach neuroses is another reason for the full and more thorough treatment of these affections.

It appears to me that one of the most important lessons developed by an intimate acquaintance with neurotic affections of the stomach is their close relationship to and dependence upon some disorder of the general nervous system. This fact is often overlooked because of the absence of striking symptoms of a general character. These general symptoms are usually of the type called neurasthenic, *i.e.*, symptoms developing out of exhaustion of the nervous system, their especial character depending upon the portion or portions of the nervous system involved. Irritability is the result of exhaustion of nerve centres; indeed the terms are almost synonymous, clinically, when

employed in relation to this system. Even when symptoms of this class are not obtrusive, one can often discover, upon thorough examination, evidences of slight irritability all along the lines of the cerebro-spinal and sympathetic systems.

Another very practical fact is the relationship of certain gastric neuroses to diathetic conditions, especially the gouty. The frequent dependence of neurotic dyspepsia, as well as the underlying neurasthenia, upon gout, I have often demonstrated to my entire satisfaction. By gout I mean those varying symptomatic and pathological conditions associated with the excessive production of uric acid—not necessarily arthritis of the great-toe joint. Notable in this group are muscular pains, itching of the skin without eruption, urticaria, iritis, neuralgias, neuritis, arterio-sclerosis, high arterial tension, valvular and muscular heart diseases, renal sclerosis, etc. The importance of a proper recognition of this relationship will be appreciated when one comes to deal with the therapeutics of the disorder. Syphilis is a much more frequent factor than is generally believed. The neuropathic syphilitic with a gastric neurosis is a very ordinary patient. We must often guess at the existence of the syphilis as it is so frequently denied, or, on the part of the patient, honestly believed not to exist. Without a recognition of the gout or syphilis, or perhaps both, as the cause of the stomach trouble, little success will attend treatment.

The form of gastric neurosis I have most frequently met is one of increased secretion with motor excitability. The principal complaint is of discomfort during the digestive process, which symptom may continue into the period of stomach emptiness, or be much increased at this time. If this is the case, eating may relieve the pain, and the patient may find himself ingesting a larger quantity of food than his nutritive state demands, as well as affording the stomach no time for rest, either of which favors a continuation of the disease. The evidence of continuous secretion is increasing discomfort with the emptying of the stomach, consequently diminished comfort before the mid-day and evening meals; and of even more importance is a night aggravation. Those who have heretofore been good sleepers become restless, wakeful, and distressed, usually four to five hours after the evening meal, and find it necessary to rise and eat in order to secure relief. Patients suffering with

this type of gastric disorder often lose flesh rapidly—so rapidly, in fact, as to lead to a suspicion of malignant disease. The appetite is often excellent, as already noticed, and it may be with difficulty that it is properly restrained. The symptoms detailed, and many others belonging to this gastric neurosis, are the result of the irritant influence of an excess of hydrochloric acid in the stomach, and caused by an unhealthy stimulation of the nerves presiding over gastric secretion. We have seen that this excess may be related to the digestive period only, or the irritant fluid may continue to be formed during the empty state of the organ, when normally it should be at perfect rest. The influence of these two forms upon the symptomatology is apparent. The form represented by continuous secretion, known as Reichmann's disease, has been considered as practically incurable by some of our ablest specialists. The accompanying motor symptoms are interesting and variable. In all cases there is an acceleration of the digestive process, due not only to the large quantity of irritating gastric juice, but to the rapid emptying of the stomach as the result of increased motor irritability. Delayed discharge occurs in some cases, and is due to a state of spasm of the circular muscular fibres at the pylorus. This may be attended by energetic efforts upon the part of the organ to disgorge itself. I have recently met a remarkable instance of this sort. The patient was very thin, and it was possible to make out rhythmical efforts upon the part of the stomach, extending from left to right, and so forceful as to raise the abdominal wall and give the appearance of a moving phantom tumor. The pylorus could be felt, and at first suggested a neoplasm; but there was a condition of greater and then less tension, altering the feel of the part and suggesting spasm. The stomach was somewhat dilated and prolapsed. Spasm may also occur at the cardiac orifice. In such cases there may even be sufficient obstruction to interfere with the free passage of a bougie or tube, but more frequently the patient has sensations of a peculiar kind referred to the cardiac orifice. It may be a sense of a lump, a slight smarting with a sense of constriction, but, perhaps most frequently, sensations which extend along the œsophagus to the throat. The same spasmodic action is undoubtedly developed in the œsophagus of some patients, leading to a sense of a ball low in the throat, with a feel-

ing of smarting or contraction. There may be somewhat of a tendency to swallow the "lump;" indeed, this resembles the "globus hystericus." In one case these sensations would come on very suddenly with a sense of swelling, leading to a choking feeling. At the worst the spells were attended by salivation, fluid pouring copiously from the mouth. They often came on during the night, especially between one and three or four A.M.

Pain and vomiting are symptoms of a higher grade. Pain in some degree attends most cases, but becomes the most important symptom in many of the more aggravated ones. There is indefinite distress during digestion in the simpler type, and a gnawing pain which becomes acute, and even gastralgic, in the graver form. It is so persistent and severe in some as to excite a fear of malignancy. Flatulence is always a symptom, and the over-irritable gastric muscle makes frequent attempts to expel it. This symptom is increased by giving way to the inclination. Vomiting is not unusual at the periods of greatest distress. I have been impressed, however, by its absence in many of the most severe cases which I have seen. In the case of a physician who was under my care for one year, much of the time confined to bed, serious ulceration of the stomach eventuating, there was an entire absence of vomiting. In three cases under my observation at this time, one of them of a severe character, there has been practically no vomiting. In one of these, a highly sensitive delicate woman, a little vomiting occurs occasionally.

Pyrosis or water-brash is an occasional symptom. During the past winter I have had the opportunity of studying this symptom carefully. At one time it was supposed to be the raising of gastric secretion, or at least that the fluid raised came from the stomach. Probably many still entertain this idea. I am quite certain this cannot always be the case, but that the fluid is usually altered saliva. I believe that in most cases it is a suddenly developed intense salivation.

In the case referred to it often came on in the after part of the night, awaking the patient suddenly from sleep, when from two or three to a dozen mouthfuls of this fluid would be rapidly discharged, often exciting a feeling of nausea, and even retching, but never with the result of bringing up anything from the stomach. A sense of constriction low in the œsophagus was

common, and suggested the possibility of a spasm at the cardiac orifice of the stomach with an accumulation in the œsophagus of saliva secreted during sleep, its regurgitation awakening the patient. This would fully account for the copiousness of the discharge upon first awaking, and the attending sensations. This fluid strikes red with ferric chloride and converts starch into sugar.

Constipation attends many of the graver cases, persons who have always been regular in their bowels often becoming at once constipated with the onset of active symptoms. In many cases, however, this is purely due to the enforced departure from the usual diet. The sudden cutting off of fruits and vegetables, the freer use of albuminous foods and lessening of exercise, are ample reasons for its development. As constipation is usually neurotic in origin, it requires no stretch of the imagination to understand why it should be a common attendant of gastric neuroses.

A serious sequence of this acid condition of the stomach is ulceration. In fact, in some form it is the precursor of most stomach ulcers. In this connection it is well to note that a degree of abnormal acidity sufficient to induce ulceration often exists for a long period of time without exciting a high grade of symptoms. In the histories of many cases I have followed with much interest, I have been certain of the existence of ulceration six times only. I am now referring to typical hyperchlorhydrias. I said "have been certain of," as it is well known that ulcer of the stomach is often present and unsuspected. This fact has been demonstrated many times upon post-mortem examination. In one case it was easy to follow, externally, the extension of an eroding ulcer, attaining a size larger than a silver dollar, and its final gradual healing. In two others there were characteristic focal symptoms. The remainder could not be located. Ulcer is prone, too, to appear in cases which have not presented the more aggravated symptoms. A lady who has long manifested symptoms of excessive acidity, never in a severe form, sent for me last June, complaining of sudden nausea, terminating in a few hours in a single hæmorrhage, which nearly ended her life. It has not recurred, and health was restored to its usual state, when, recently, as the result of gross abuse, a highly aggravated hypersecretion has occurred, lasting

for some time, but unattended as yet by hæmorrhage. Since writing the foregoing, this patient has died of peritonitis following perforation. There are, of course, other factors entering into the ætiology of stomach ulcer, but none comparable with abnormal acidity.

Diagnosis.—The symptom complex usually leaves no doubt as to the character of the affection. The distress during full digestion, and in the more aggravated cases, during the period of empty stomach; the frequently improved condition on awaking in the morning, the flatulence and acid eructations, the loss of flesh, constipation, and, a feature of importance not mentioned heretofore, viz., a good appetite, with, usually, relief from eating, are sufficiently indicative of the nature of the disease. In regard to the two forms, *i.e.*, temporary and persistent hypersecretion, I think you will observe that patients who complain of the continuous variety have, often for years, suffered from the milder form of trouble. The temporary form, then, usually precedes for a long period of time the persistent one. Another thing I regard of the greatest importance in this connection is the personal history of the patient. In most a dyscrasia can be demonstrated. Usually it is the gouty one. So often is this the case that I should be almost inclined to designate this affection as a *gouty neurosis of the stomach*. This might be an exaggeration. It might not. For who knows precisely what gout is? Who knows that it is due to uric acid poisoning simply and alone? That uric acid is the only essential ætiologic factor? The Italian school especially lays much stress upon toxic albumins absorbed from the digestive tract, and we have all read what has been written upon auto-infection from the alimentary canal. But whether uric acid is or is not the specific irritant, it is usually, like the hands upon the watch face, a valuable indicator. Most of these patients, in other words, manifest a history of uricacidæmia, or of oxaluria. Some are subject to pronounced neurasthenia. In others some neurasthenic group or groups are present, or the patient has been neurasthenic in the past.

An absolute diagnosis, however, must in all cases rest upon an analysis of the gastric contents. The first step in this process is to determine whether there is hypersecretion; secondly, to learn whether it is intermittent or continuous; thirdly, to

determine the total acidity. The primary or secondary character of the trouble must be determined by an analysis of the patient's history and present general condition. The test meal and the stomach tube, with a few reagents, are all that is usually required. The examination must be made during full digestion as well as during the period when the stomach should normally be found empty, *i.e.*, at least seven hours after a meal. The early morning is the most acceptable time for the latter examination. Upon this point I desire to say that it is an error to be governed by a single analysis. In speaking of the symptoms, it was asserted that continuous hypersecretion was in most instances simply a later stage of the intermittent form. To this I must add that the transition from one to the other is not usually abrupt, nor the new condition continuous. Some days the secretion may be excessively acid during digestion only, and upon others it may continue through the periods of emptiness. Of the various reagents for determining the presence of free hydrochloric acid in the stomach contents the most satisfactory is the Günzburg solution :

R. Phloroglucin,	. . . . .	2 grammes.
Vanillin,	. . . . .	1 gramme.
Alcohol,	. . . . .	30 c.c.

One or two drops of this, together with the same quantity of gastric contents, are placed in a porcelain capsule and heated over an alcohol lamp. If free hydrochloric acid is present, a brilliant red reaction will appear. The intensity of this will give the experienced a fairly correct idea of the comparative quantity of hydrochloric acid.

It may not be amiss to barely refer at this moment to a test for the free organic acids.

Uffelmann's solution is most in use for detecting lactic acid and is composed of

R. Carbolic acid solution,	. . . . . (1-20)	10 c.c.
Distilled water,	. . . . .	20 c.c.
Liquoris ferri perchloridi,	. . . . .	1-2 gtts.

This fluid has an amethyst-blue color. It must not be kept too long. If a solution containing lactic acid be added to some of this reagent the violet color will change to a canary yellow. Free hydrochloric acid decolorizes. Acetic and combined hy

drochloric acids give a yellowish-brown, and butyric acid a grayish opalescence.

Treatment.—The purely symptomatic treatment of these cases by means of medicinal remedies is very unsatisfactory, while, in association with proper diet, exercise, etc., medicines are of decided value. The constitutional condition which we have seen to be so variable indicates that many lines of treatment must be followed in properly meeting all cases. With proper conservatism in the management of some cases I may say that the most generally successful treatment is one favoring increased metabolism and increased elimination of excrementitious matter—an effort, so to speak, to regenerate the man. Unfortunately it is not always practicable, the patient being unable or unwilling to attempt the carrying out of the method. Systematic physical training is the first step. In suitable seasons horseback riding, wheeling, and an almost continuous life in the open air, are of first importance. In inclement weather exercise should be regularly taken in a gymnasium or at home. Hydrotherapy in the form of cold sponging, baths, especially the rain- and shower-bath, should be employed in association with exercise. While proper caution must be exercised not to subject a feeble patient to too violent exercise, the tendency, I am sure, will be to think many unfit who would improve rapidly under its prudent employment. Such, at least, has been my experience. Walking is the form of exercise least likely to be beneficial. A “Rest Cure” has proven an excellent initiative treatment for some persons who were unfit to begin active exercise.

The management of the diet is scarcely of less importance. There is, perhaps, no better place to make an important statement relating to diet than here, *i.e.*, that the influence of food is in many cases revolutionized at once by a radical change of habits, environments, etc.; or, to make the statement from the opposite standpoint, the power to digest easily and comfortably is sometimes promptly conferred upon the patient by a change of air, exercise, etc. I have seen patients who for weeks and months have been living in distress, notwithstanding the greatest care in diet, able to eat pork and beans and flapjacks and maple syrup with impunity after a few days’ tramping in the woods. Change should therefore be tried in all obstinate cases.

The food should be of the blandest character. All condiments must be absolutely avoided, and salt especially must be taken in as small quantity as will at all satisfy the palate. Foods rich in albumin are most satisfactory, as they are easiest digested and possess the further advantage of combining with the hydrochloric acid and alleviating pain. Meat, eggs and milk are the most important. Certain rich meats, as turkey and duck, are too stimulating for some. The milk had better be sipped slowly, as it then coagulates in fine flakes, and not in large masses. The milk-curdling ferment is always in excess in these cases. 10 to 15 grains of bicarbonate of soda can usually be added to each 8 oz. with advantage. Sometimes it is better to dilute the milk with water or lime-water. It will be unusual to meet one who cannot employ milk, if these precautions are carefully followed. As absorption from the stomach is normal and digestion rapid, water may be allowed *ad lib.*, and should be advised, if it is not demanded. A free use of water favors peptonization of the often concentrated stomach contents, and dilutes the hydrochloric acid, thus lessening its irritating influence upon the stomach. Alcoholics, tea and coffee, are, as a rule, to be positively prohibited.

Functional rest of the organ is a prominent object of treatment, and it is wise, if possible, to limit feeding to the regular three meals daily. There is a strong temptation to eat between meals in order to relieve the distress, but this had better be prohibited. In the continuous form of long standing the absorptive ability of the stomach is below the normal, and an excess of fluids tends to accumulate and cause dilatation. This is, at least, the ordinary explanation. My own reasoning leads me to consider it due rather to pyloric spasm, with consequent retardation of the flow into the intestines. This is supported by recent physiological observations which indicate that the power of the stomach to absorb liquids is very small indeed. If there is good reason for ordering a dry diet in any case, it will be well to give rectal or colon injections of water several times daily, otherwise the urine will become concentrated and irritating, and many of the body functions impaired. Should symptoms of ulcer develop, the patient should be put bed, and be fed solely by the rectum, receive ice and water (with caution) by the mouth, have a wet compress constantly upon the epi-

gastrium, and continue this treatment until relief of the urgent symptoms is assured.

Excessive acidity should be controlled by the use of a good article of bicarbonate of soda. Ten grs. dissolved in an ounce of water should be repeated every ten minutes, as recommended by Herschell, until the annoyance ceases, and then be stopped. This agent may be employed for a long time without any ill result. The ordinary method of giving large doses is not wise, as the object should be to just neutralize the excess of acid present. If the stomach contents are rendered fully alkaline, it stimulates the secretion of hydrochloric acid, which is, above all things, to be avoided. Usually two or three doses prove sufficient.

I shall mention but a few medicines. At the head of all, in my experience, is *atropin sulphate*. In order to the best results it must be given just short of producing its physiological action, a principle I have for years contended should guide us in the administration of many drugs. Tablets of the third decimal trituration are most convenient. One, two, three or more may be given before each meal, and in some cases a second dose after each meal. In persistent hypersecretion with night aggravation, a dose at bedtime, or preferably, when possible, about an hour before the aggravation develops. The action is, to the patient, often miraculous. I can but illustrate this by a couple of cases I have seen during the past two months. Strange to say, both were wives of Philadelphia physicians. Both had severe pain during digestion, but especially when the stomach became empty; were living upon most restricted diet, losing flesh (one especially), and had resorted to narcotics, as no medicine had done any good. In both, the patients professed surprise at the immediate results obtained from the use of atropin. One said "I knew within three hours that I had the right medicine at last, and I have had practically no pain since, in spite of an enlarged diet." The other has just written me: "I am very well in spite of a full diet, including a little fruit cake, etc." In both there was pronounced uricacidæmia, and in one a history of long-continued stiff knees and other gouty symptoms. It is far from my intention to exploit atropin as a specific for this form of gastric neurosis. Undoubtedly it must fail in many for easily conceived reasons, but when such results are so fre-

quently met in the treatment of so rebellious an affection, it is difficult to restrain one's enthusiasm. The gastric neurotic is prone to recurrences, and this must be so in most cases, as the general habits and environment of the individual cannot always be changed. Anyone who will take the pains to read Ewald, Boas, Mathieu, Einhorn, Martin, Hemmeter, Herschell, and other authorities upon "Reichmann's disease," will discover but scanty hope of cure extended, and if to this is added a little experience with ordinary therapeutic methods, the value of atropin will be appreciated. My first feeling was that this agent would prove a mere temporary relief, but in this expectation I have been happily disappointed. Several cases of marked severity which have been treated with this agent remain fairly well after two years have elapsed.

Anacardium has proven second in value, and has relieved two cases in my own experience after atropin had failed. The symptoms relating to the nervous system and stomach found in the provings and clinical confirmations of this remedy strongly suggest its employment. I have given it in the second and third decimal dilutions.

Iris has also given excellent results in some cases, especially when there was a fixed pain in the epigastrium, taking on a gastralgic type at times. Water-brash, nausea and a frequent tendency to vomiting, but never actual vomiting, were the symptoms attending one typical case relieved by iris. The patient also suffered from sick headache, also relieved by the same remedy.

Nux vomica and *ignatia* have been of some benefit, prescribed on their well-known characteristics.

Arsenite of copper meets many of the symptoms, and is one of the most highly prized medicines. Motor excitability of the stomach is the prominent indication. Spasm of the cardia and pylorus, muscular contortions of the organ, which may be visible through the abdominal wall of a thin person, sensation of a lump deep in the œsophagus, cramps in the calves, feet, etc., are some of the indications. Dr. Tuller tells me that this drug is being used recently in the Paris hospitals as a nerve tonic, which influence is corroborated by my own experience. The second and third decimal triturations have been usually given.

Gelsemium has been of service in the course of some cases

occurring in feeble, neurotic, catarrhal persons. In one case it relieved at times the continuous hypersecretion and attacks of copious salivation. I was led to it by reason of attacks of acute rhinitis to which the patient was subject.

Some little experience with *cocculus* has been favorable, and I intend to make more frequent use of it. The cramp, contractive pain, etc., at pit of stomach, the flatulence in both the stomach and bowels, the nausea, vomiting, water-brash, etc., all suggest its use. Pain has been the symptom for which I have especially prescribed it. Pain of the gastralgie type.

When fermentation is exceedingly troublesome subgallate of bismuth after meals is of great service, especially if diarrhœa is present. It tends in many persons to produce constipation, and must often be avoided for this reason. Beta-naphthol-bismuth is free from this objection and equally as efficient, if not more so. Terebene, on disks, is another remedy of equal value. This symptom of flatulence is such a prominent and troublesome one that all our remedies are sometimes too few for relief. *Argentum nitr.* may be of benefit if a gastric catarrh has been set up, and especially if flatulency is the prominent symptom. In some of the very painful cases, defying ordinary treatment, oxide of zinc in one-grain doses, or codein in small doses, may for a time prove excellent palliatives. The necessity for such palliatives is greatly diminished, however, by the use of lavage, one of the most efficient measures employed in the treatment of hypochlorhydria. In most cases it is sufficient to employ the tube each morning before breakfast. In others it can be employed during periods of stomach emptiness later in the day. The relief is often so great that the patient learns to employ the treatment with such assistance as can be secured at home. No obstinate cases should be allowed to continue without the use of lavage.

Galvanism should also be tried in all refractory cases. One electrode should be placed over the epigastrium; the other, a long pad, upon the spine, covering the cervical and dorsal spine. The direction of the current must be decided by the effect, as the patient is often conscious of greater relief from the positive or negative at the epigastrium. Galvanization of the pneumogastric can sometimes be added with advantage. The treatment should be applied at least once daily, often three times daily.

I might add that *Carlsbad (Sprudel) salt*, in water—hot or cold—gives a better result, in some, than bicarbonate of soda, for the neutralization of the excessive acid. It also serves as a laxative agent, which is often demanded for the obstinate constipation. The usually associated intestinal condition demands consideration but is postponed for future consideration.

BILE IN THE URINE OF A PATIENT TAKING PHENACETIN.

BY CLIFFORD MITCHELL, M.D., CHICAGO, ILL.

A CERTAIN jaundiced patient, suffering from severe headache, took phenacetin. The urine passed at the time was examined by the writer, with the following curious results:

Physical Characteristics of the Urine.—The color, when the urine was viewed in bulk of 500 c.c. or more in a glass graduate, was distinctly reddish, and the reaction acid. The color was about that of No. VI. Vogel color-scale, but was nearer that of a 1 per cent. solution of potassium dichromate. Held up to strong light in a test-tube, the bright yellow tint of biliary urine was perceptible, but in a dark corner of the room the reddish color prevailed. The foam was abundant, persistent, and of a faint yellow tint. The specific gravity was 1014. The odor was slight and, unlike that of most biliary urines, somewhat suggesting that of blood. There was, however, no blood in the urine. The stain on filter-paper was light yellow.

Action of Reagents and Test-Liquids.—The following tests for bile were tried:

1. The urine was floated on about an inch of nitrous acid. Result: whitish zone of coagulated albumin, but no green color anywhere.

2. The urine was floated on four solutions of iodine in alcohol, namely, tincture of iodine, the same diluted with alcohol in strengths 50 per cent., 25 per cent. and $12\frac{1}{2}$ per cent. respectively. Results: With the tincture and the tincture diluted with equal parts alcohol, a very slight dull-greenish color was seen beneath a white ring. The color faded completely in less than an hour. With the weaker solutions a perceptible green

ring of color of a hair-line in thickness was obtained, which gradually faded away in a few hours, leaving only the white ring of albumin visible. (Marechalt's test.)

3. Jolles's test was applied as follows: To 50 c.c. of the urine, after acidulation with hydrochloric acid, solution of barium chlorid was added in excess. An unusually slight precipitate of sulfate was obtained. The mixture was then shaken with 5 c.c. chloroform and allowed to stand until the latter had settled, when it was transferred by means of a pipette to a watch-glass, and evaporated on the outside of the water-bath. A greasy residue was obtained, in which a mass of large needle-shaped crystals could be seen. A few drops of a mixture of two parts nitric acid to one of nitrous were added to the residue, with result that a yellowish-colored fluid with green-yellow edges was obtained. The greenish tint quickly faded. In other words, although bile was present in considerable quantity, none of the above chemical tests were satisfactory. The writer had found Jolles's test for bile extremely satisfactory in other cases, but in the urine of this patient, who was taking phenacetin, repeated trials of it were negative in results.

Marechalt's test with alcoholic solution of iodine, recommended by Ogden, gave a slight green color, but the green soon faded, instead of remaining twenty-four hours as it is said sometimes to do.

The presence of albumin in the urine was easily demonstrated by the heat test, and by the ferrocyanid test. The latter, used according to Purdy, showed by the centrifugal method 8 per cent. bulk, or 0.167 per cent. weight by Purdy's table.

Inasmuch as neither nitric acid nor nitrous gave any color zone, there was no difficulty in recognizing the albumin ring with these acids by the contact method.

Sugar Test.—The urine was tested for sugar with Haines's test, but no reduction of the test-liquid was noticed, either in the hot liquid or after cooling. Equal parts of the urine and of Fehling's solution when heated turned dark green, and this color remained after cooling. No precipitate could be observed in either case.

The urine being tested with 20 per cent. *ferric chlorid* solution, darkened slightly, giving a scarcely perceptible wine-red color both in the cold urine and in the hot.

The *indican* test resulted in the formation of a moderately dark violet coloration.

Silver nitrate gave the usual white curdy precipitate, which turned a light brown on standing, but the brown was barely perceptible.

The *barium chloride* precipitate of sulfate on standing over night showed a faint greenish tint.

Hydrochloric acid, sp. gr. 1.20, added in proportion 10 c.c. to 200 c.c. of the filtered urine, failed to precipitate any crystals of uric acid after standing sixteen hours. The mixture turned dark green.

Microscopic Examination.—This revealed numerous granular casts all stained yellow by the bile pigment; also various epithelia and pus corpuscles similarly stained. Numerous zoöglæa masses of bacteria were present, but were not affected by the pigment.

The writer next tested another sample of urine voided more recently by the same patient, with the following results:

1. The three bile tests as above were unsuccessful.
2. A trace of albumin was found with heat and 50 per cent. acetic acid. On addition of the acetic acid a dull green color appeared, which, however, gradually became less and less pronounced.
3. Hydrochloric acid in the cold urine gave the same green.
4. Barium chlorid solution gave about the same green. Jolles's test for bile pigment resulted in the formation of a green sulfate precipitate with a green supernatant liquid, the whole having a dull olive-green tint when shaken with chloroform and let stand.
5. Titration with uranium nitrate, on the water-bath, the urine being first treated with sodium acetate, gave the usual precipitate of phosphate, but no green color.
6. Silver nitrate solution gave the usual white chlorid precipitate, which soon turned noticeably brown.
7. Ferric chlorid solution gave a slight wine-red color in the cold urine and in the hot; as in case of the former specimen, however, the color was not pronounced.
8. The various tests for phenacetin in urine (amido-phenol or amido-phenetol) were tried, namely, with ferric chlorid solution, hydrochloric acid and ferric chlorid, and dilute chromic

acid solution. No satisfactory results could be obtained beyond a slight wine-red with ferric chlorid solution. Although the urine of a patient containing phenacetin is said to contain reducing compounds, Haines's sugar-test was not affected, and the green color resulting from use of Fehling's solution has been noticed by the writer to occur quite often in cases not similar to this one.

Inasmuch as in a former article in the *HAHNEMANNIAN* the writer has described a urine containing the colorless chromogen of methylene-blue which behaved with reagents somewhat in the same manner, the following table may be of service in differentiation :

COLORLESS CHROMOGEN OF METHYLENE-BLUE IN URINE. BILIARY URINE OF PATIENT TAKING PHENACETIN.

Urine on exposure to air turns greenish.	Urine remains red.
Heated, with addition of acetic acid, a persistent bright blue-green.	A dull, rather dark, green, gradually less and less pronounced.
Titrated with uranium nitrate, etc., a bright blue-green supernatant liquid.	No green color.
Silver nitrate solution (1 in 8) gives curdy-white precipitate, immediately blackening at the bottom with light blue-green supernatant.	A curdy-white precipitate slowly turning brown. No green supernatant.
Barium chlorid: white precipitate, faint blue-green supernatant.	Dull olive-green precipitate and supernatant.
Ferric chlorid solution (20 per cent.): olive green color below the phosphates.	Slight wine-red below the phosphates.
The green colors can be obtained when the urine is several days old.	The green colors cannot be obtained when the urine is three days old.

The peculiarities of biliary urine in case of a patient taking phenacetin may be summed up as follows:

1. Although bile was abundantly present (as shown by the foam, by the staining of filter-paper, and of the tube-casts and epithelia in the sediment), the nitrous acid test by contact, Marechal's iodine test, and even Jolles's delicate test, all failed to give characteristic results.

2. Acidulation with hydrochloric acid and addition of solution of barium chlorid (1 to 5) gave in one sample a slight greenish precipitate; in the other, a pronounced olive-green one.

3. Testing for albumin with heat and 50 per cent. acetic acid

gave no color in one sample, but in the other a dark green, gradually becoming less and less pronounced.

4. Addition of hydrochloric acid, in proportion of 1 to 20 of urine, gave in one sample a slight dark green without precipitate of uric acid crystals; in the second sample a pronounced green.

5. No green color at all could be obtained with any of the above tests after the urine had become three days old.

Samples of the phenacetin which the patient had taken were obtained and tested. The usual reaction with hydrochloric acid and chromic acid solution was obtained. The bromine water test of the cold saturated aqueous solution was negative, showing absence of antifebrin and exalgin as impurities. Added to melted chloral hydrate, no color was observed at first; on cooling, a faint pinkish tint pervaded the mass. Inasmuch as hydrochloric acid, heat and acetic acid, and barium chlorid solution gave no color with aqueous solutions of the phenacetin, either cold or hot, the writer thinks that the normal urine of patients taking phenacetin should be tested to determine whether the green color can be obtained in urine (not containing bile) with these reagents. If not, then the conclusion would be that bile pigment may form with phenacetin some new compound in the organism the character of which we are unfamiliar with. There is, of course, a possibility that some accidental impurity not detected by the standard tests for phenacetin may have been responsible for the green colors obtained in the biliary urine; but as the drug was taken in small doses this hardly seems probable.

Finally, the writer has often tested urine containing bile-pigment with the reagents producing the green color in the urine described above, but never saw this color before.

EUMENOL AS AN EMMENAGOGUE. MULLER.—The writer has tried Eumenol-Merek, which is an extract of the Chinese emmenagogue Tang-Kui (Ma-mu), in eighteen cases. Two cases did not report again; in two cases of climacteric disorders, intermittent pain and parametritis, there were no results. The remedy had a favorable effect in all cases of inflammatory affections of the lower abdominal region, especially if associated with delayed menstruation. A thin, watery flow became darker and more profuse. A case of membranous endometritis was benefited. It was given in half-drachm doses, and it does not have an abortive effect. Larger doses produced headache.—*Centralblatt für Gynäkologie*, No. 38, 1900.

PELVIC INFLAMMATIONS.

BY DEWITT G. WILCOX, M.D., BUFFALO, N. Y.

As pelvic inflammation is an accompaniment of nearly all diseases of the female pelvis and lower abdomen, and because so large a per cent. of women suffer from such lesions, it behooves every physician in general or special practice to be extremely well versed in the pathology and treatment of this affliction. Great as is the responsibility upon the surgeon and gynæcologist to whom these patients come for radical treatment, it rests still greater upon the family physician or general practitioner into whose hands they fall primarily, while the dragon disease is yet a young suckling and may be readily strangled if correctly understood. It is not difficult, with our better knowledge of germ transmission and multiplication, to understand how a simple specific vaginitis may become a cervicitis; how a cervicitis may quickly extend into an endometritis; how this latter, with its ready and open communication with the tubes, becomes a salpingitis; how this salpingitis, with its resulting drop of pus or multiplying germs, may find its way through the open fimbriated extremity and infect the ever sensitive peritoneum and light up a pelvic peritonitis; how this may extend and produce a general peritonitis. Such is the chain of events which is so likely to follow a simple gonorrhœal vaginal infection, unless effectually checked in some one of the stages. Each progressive step renders the disease more difficult to reach, more damaging in its onslaught, and less certain of cure. Obviously, therefore, wisdom and humanity prompts us to be energetic in the first stage.

We will first consider briefly the early recognition and prompt treatment of pelvic inflammation produced by gonorrhœal infection.

If an otherwise healthy woman comes to her physician complaining of a burning, smarting sensation in passing urine, he is omitting a great part of his duty toward her if he dismisses the complaint with the mental conclusion of "a little cystitis."

In gonorrhœa the attack is sudden; the patient may be feeling perfectly well, when suddenly, upon micturition, she is conscious of a burning, smarting sensation; this is increased at each succeeding voiding, until the pain becomes very acute.

If she now consults her physician, it becomes his duty to make a careful inspection of the parts, as she has told him sufficient to arouse his suspicions concerning the true cause of the disease. This examination discloses a highly sensitive and inflamed meatus urinarius, together with a creamy discharge exuding from the vagina and urethra. The vaginal canal is sensitive, causing much pain by the introduction of the finger. The collection of a few drops of this discharge upon a glass slide, staining and drying, will disclose the presence of the gonococci; but in the absence of such confirmation the physician should not allow valuable time to be lost merely for the sake of confirming his suspicions, which already have sufficient support. He should begin his treatment then and there. The first process of treatment, while the disease is yet a specific vaginitis, is to cleanse thoroughly the vagina and external genitals. This is best done at the time of the first examination with the patient in the lithotomy position; in fact, there is no other effectual method of doing it. Place a douche pan under the patient's hips and wash out the vagina with the same thoroughness as though preparing for a vaginal hysterectomy. Next, douche thoroughly with a 1 to 5000 bichloride solution, and finally use a 1 per cent. argonine or protargol solution. The patient should then be put to bed and a vaginal douche given every three hours, consisting of a 1 to 5000 bichloride solution. This douche should be given while the patient lies upon her back with a douche-pan under her hips. I have little faith in the douche which some patients take in a squatting position.

In the large majority of cases a complete cure can be effected in from ten days to three weeks. We come now to the next stage, gonorrhœal endocervicitis. Let us suppose that upon making the first examination we find not only the external genitals inflamed and bathed in pus, but we notice pus escaping from the os uteri; the cervix is inflamed, enlarged, sensitive and eroded. Again the presence of the gonococci determines the precise nature of the discharge, but again is the physician

not justified in waiting more than forty-eight hours to determine such presence. It is better to mistake a simple non-purulent discharge for a purulent one, and treat as the latter, than to delay the treatment of a specific endocervicitis until the infection has reached the tubes and the disease becomes incurable medically. Here, again, the treatment should be prompt and vigorous, for it is quite possible the infection has not yet reached the cavity of the uterus, and the disease may be stayed while in the cervical canal.

The same treatment as above outlined is to be observed here, plus the cleansing of the cervical canal. Bichloride, 1 to 5000, should be used freely to wash out this canal, and finally the canal should be painted with tincture of iodine by means of an applicator. Under no circumstances should a probe or dilator be inserted into a uterine cavity wherein pus is discharging from the os without first rendering the cervical canal sterile, for it is quite possible the uterine cavity may not have become infected, and no surer way could be devised of infecting it than by such introduction of a sound.

Third stage of the disease. How may we know when a woman is suffering from gonorrhœal endometritis, acute or chronic? In the acute stage, she will present herself with all of the foregoing symptoms of smarting and frequent urination, profuse discharge, swollen genitals, which she may innocently ascribe variously to cold, too frequent coitus, injury, exposure, etc. These symptoms, she tells us, were gradually subsiding when she became unwell. About the second or third day of her menstruation she began having severe pains in the uterus different from her unwell cramps, the flow lasted longer and became more profuse. The uterus became very tender, and she felt ill all over. After the flow ceased she had a very profuse yellow discharge from the uterus; she was feverish, and took to her bed; her entire abdomen became sore. She has gradually improved, but is conscious of the uterus every step she takes. We make an examination, find the uterus enlarged and exquisitely sensitive; os eroded, so that very little epithelium appears; discharge thick, yellow, tenacious. With those symptoms and conditions present in a woman who has not recently had a miscarriage or confinement, it will not require a microscope to determine the diagnosis. She has gon-

orrhœal endometritis. And please observe she began complaining almost immediately after her menstrual period. A woman may have specific cervicitis for three weeks without having endometritis, but when the menstrual epoch approaches the uterus is congested, the lymphatics active, the os is open, and intra-uterine infection takes place.

I venture to say that seldom is the physician placed in a more responsible position than when he confronts just this situation. Here in the uterine cavity which he is examining lies coiled a serpent, ready to fasten its poisonous fangs into the sensitive peritoneal structures which so abundantly surround it, and which, when once infected by this poison, will almost to a certainty produce such destructive changes as to imperil the patient's life, produce chronic invalidism, or force the issue of a dangerous operation. Will the physician be able to destroy the venom of this serpent before it has fastened its fangs into the sensitive tissues, or will he sit by in "innocuous desuetude," trusting to inert internal remedies? The situation is now surgical, and must be met by surgical measures—an anæsthetic, dilation and sterilization of the uterine canal, curettage and thorough douching. The object of the treatment is to wash out the pus and destroy the gonococci. I do not believe it possible to cure gonorrhœal endometritis by any method short of curettage and thorough intra-uterine douching, for the reason that the gonococci burrow deeply into the submucous tissue and cannot be dislodged by simple washing.

The fourth and last stage. Gonorrhœal salpingitis and peritonitis. In this act the serpent has either escaped the physician or was able to get in his poison-infecting work before the physician appeared upon the scene. At any rate the serpent is making a glorious success of his part, and the curtain falls with his victim upon the operating table. Fortunately for the poor victim, and to the relief of the overstrained spectators, modern science rings up the curtain and shows surgery with his foot upon the serpent, while he is cutting out the poisonous tissues and infusing new life into the hitherto abandoned victim.

How may we recognize gonorrhœal salpingitis? A patient presents herself complaining of pelvic pain; she may have had it for days, months, years. Her face denotes her suffering. Her posture upon standing suggests pelvic trouble. If she is

young she has lost the bloom of youth. If she be middle-aged she appears haggard. She has pain over each ovary, and the pain runs down the front of her thighs. She suffers more when she menstruates. Her bowels are constipated, her micturition is painful. She may or may not have a uterine discharge. You inquire into her history, and at first obtain but little. She has had the pain so long she does not remember how it began. Yes, now that you remind her, she did have what the doctor called inflammation of the bowels or peritonitis a long time ago. She was laid up in bed some weeks, had quite a fever and suffered terrible pain. Yes, she remembers having a discharge from her genitals previous to that, which was but a few weeks after her marriage. She recalls the painful urination, and how sick she was at her next menstrual period, and really she thinks that was the beginning of her ill health. You find lumps on each side of the uterus; they are the thickened, inflamed, densely adherent tubes and ovaries. The uterus is fixed and sensitive, and the pelvic floor inelastic. Again, she may tell you of the frequent attacks of peritonitis she has every time she takes a little cold or her menses are delayed or she indulges in too frequent intercourse. In her case you find the tubes in a constant case of subinflammation, which become reinfected each time the endometritis is lighted up with a fresh inflammation, each attack rendering the tubes worse because of the greater accumulation of pus therein. Such is the desperate status into which many women eventually fall when the first symptoms of their gonorrhœal infection fail to impress the mind of their physician with sufficient force to arouse him to that prompt and effectual treatment which alone can effect a cure.

Then there is *another* source of infection which leads to pelvic inflammation no less destructive, that of septic inflammation of the lining of the uterus, due to an abortion or confinement, to the introduction of septic instruments into the uterus, or degenerating polypi. In this case the inflammation starts in the lining of the uterus instead of the vagina, and in consequence has a less distance to travel to reach the pelvic peritoneum, which it does through the medium of the tubes. There is no difference in the character of the infection following abortion than that following confinement, but generally

quite a difference in the degree of severity. The uterus at six weeks of pregnancy is not the same as that after full term delivery. In the former the walls are *firm*, the lymphatics not over developed, and the power to throw off infection comparatively great. In the latter the walls are flabby, interspaces large, lymphatics developed, which aids the absorptive powers greatly, thereby adding material opportunity for rapid and dangerous general septic infection, or the walls of the uterus may slough after confinement, producing a putrid infection, all of which affects the pelvic peritoneum quickly, and results in those dangerous forms of septic pelvic peritonitis. Hence we shall consider the treatment under that of *septic* endometritis and *puerperal* endometritis.

When a uterus has been infected through abortion or septic instruments, we find the patient generally begins complaining first of a sense of weight and fullness in the pelvis; a slight temperature may then be discovered, or she may complain of a chill. Soon the fullness becomes a pain, which may so increase through spasmodic uterine contraction as to become agonizing; in from twenty-four to forty-eight hours a slight discharge may be discovered oozing from the os; later this becomes purulent or mixed with blood; an examination discloses an exquisitely sensitive uterus firmly fixed in the pelvis, the cervix large, and generally ever ready to bleed. In a few days these acute symptoms subside, and fortunate is the woman who is left with no more serious result than a chronic endometritis, which, however slight, is ever ready upon proper provocation to burst into another acute attack, and thus repeat itself. Much less fortunate, however, is she who has developed a salpingitis or peritonitis in consequence of the extension of the septic material and is now well started on the road to chronic invalidism. How can we avert so unhappy a result? This is the question which the general practitioner must settle quite as frequently as the gynæcologist. What would he do if he had a *septic wound* on the surface of the body? He would remove the stitches, clean out thoroughly, and then destroy the streptococcus or staphylococcus with some germicidal solution. Why not be as generous and as rational with an infected uterus? Why sit down and wait for this infected cavity to take care of itself? There is no reason for not treating it the same, and

is malpractice to omit it. The treatment in every case as above outlined is thorough cleansing of the genital tract, dilation of the cervix under chloroform and curettement of the uterine cavity, followed by irrigation with a 1 to 10,000 bichloride and drainage with gauze. I do not approve of using strong escharotics or powerful antiseptics upon the uterine membrane, because of the tendency to destroy deep connecting tissues and produce scars which become dangerous and painful.

Next comes the *puerperal* endometritis; that found in septic inflammation in the uterus which follows delivery. It is by no means an *easy* matter to determine this affection in the early stages. Nearly *every* parturient woman has a little temperature the third or fourth day after delivery. Many have some little uterine soreness, not a few have foul-smelling lochia, yet but a very small majority of such women have puerperal endometritis. How shall we distinguish? Were we all expert bacteriologists, or had such at hand, the question could be much more readily solved; but even then I think the majority of us rather depend upon the clinical symptom than rely too implicitly upon bacteriological provings, except in the hands of experts. If at any time within three weeks after delivery (I say three weeks, for only in rare cases can a woman have a septic endometritis depending upon delivery after that period) a woman shows a marked temperature preceded or not by a chill, a tender uterus, scant and foul lochia, some intestinal bloating, decided fullness and pain in the pelvis, we can conclude pretty accurately that she has, or is about to have, septic endometritis.

We can feel more positive of this if the milk has already been established; if the bowels have been emptied, and there is no suspicion of malaria. Even if we cannot rule out the foregoing, it is better to assume the existence of the infection than disregard it and lose our patient, or subject her to a long term of illness. It is perfectly proper here to play according to Hoyle. When in doubt, irrigate at least. No harm can be done by this procedure under proper precautions.

Treatment.—Upon the very first suspicion of septic puerperal infection, the vagina should be cleansed with green soap and water, douched with a 1 to 10,000 bichloride, hands and instrument sterile; the uterus then irrigated with the same. If the temperature has not subsided somewhat within two hours, re-

peat the procedure, and continue the repetition every two hours for twenty-four hours, when, if the temperature still persists, curette. This should be done thoroughly, but not harshly, remembering that a puerperal uterus is not as firm and resisting as the non-puerperal, and that if the inflammation has been severe and prolonged, the puncture of that organ with the curette is not at all difficult.

There are some peculiar features about puerperal endometritis which are only just beginning to be understood, and one such is, that the more rapid the onset of the attack and the more virulent the infection the less pronounced are the *local* symptoms, the more profound is the *general septicæmia*, and the patient is dying before we have fully realized her condition. This can only be explained by the fact that the uterus in such cases is either dormant, to begin with, or is so overwhelmed by the invasion of the virus that, instead of rallying and making an attempt to throw off the poison by the production of lymph and pus, it simply acts as a sponge, sucking the virus into the circulation, and producing a general septicæmia before we have even an evidence of local inflammation. It is in such cases we are deceived, because, not finding any foul lochia, tenderness or discharge, we cannot believe that infection has taken place. It is here that local treatment is of little avail, and the patient is almost inevitably doomed.

Again, there is another class of cases, and we have all seen them, wherein one washing or curettement seems to have remedied the difficulty, when in a few days it returns with all its severity.

This is repeated for days, and even weeks. Each curettage seems temporarily to overcome the disease, but upon each return it shows more virulence, until death ends the struggle. Such conditions may be attributable to a sloughing surface of the uterus, which affords an excellent breeding-ground for septic germs, and no sooner are they washed out than they reappear; or, again, it may be due to harsh curettage, wherein the wall of the uterus is scraped raw by the sharp instrument, used with too great force. In such cases a thorough wiping out of the uterine cavity and the insertion of a gauze packing, frequently repeated, is preferable to curettement. But if neither avail, and the septic process goes on, hysterectomy is the only

procedure that will promise any hope. Averse as I am to so radical a measure following a confinement, yet I am convinced that in such cases as just cited, wherein it is evident the infection is lighted up every few days from a degenerating uterine surface, I recommend it unhesitatingly.

Thus far we have considered how to prevent pelvic inflammation by checking the processes which lead up to it. Now, just a few words of how to treat it when well established. It is to be borne in mind that in the acute stage of pelvic inflammation there is first thrown out *serum*; here the process may be arrested, but if not it goes to the next stage, that of lymph production. This lymph in time organizes and produces those adhesions, which we have all seen in cases of severe pelvic inflammation. If, however, the degree of inflammation is great, this lymph breaks down soon after being formed and becomes pus. The sequence of events therefore is, 1st, serum; 2d, lymph; 3d, pus. If the inflammation can be checked while yet in the serum stage, we shall have no bad consequences. If passed to the lymph stage unattended to, it must surely form adhesions which will render a woman more or less of an invalid for life. If it goes to the *pus* stage, it becomes suppurative pelvic peritonitis, and the man who cures his patient of *that* disease well nigh performs a miracle. *Treatment*: medicine and local applications may arrest some cases, but will fail in many. That which is most rational and promises more, particularly in those cases which are unquestionably caused by septic endometritis, is an opening into the pelvis through the vagina, *via* the posterior cul-de-sac. This is so easy of performance that I do not hesitate to advise any practitioner of ordinary surgical skill to employ it. It secures immediate and effectual drainage, opportunity for washing out the pelvis, and an arrest of the lymph production.

The patient is placed under an anæsthetic, the perineum retracted, the cervix seized and pulled forward, the uterus everted and irrigated; the mucous membrane is then cut with scissors at that fold so noticeable just at the posterior cervicovaginal junction. After incising the mucous membrane from side to side in a semicircle, it is a very easy matter to push the finger through into the cul-de-sac by keeping the former close to the uterus as a guide. Occasionally a tough or thick peri-

toneum will require the scissors to open it. Upon opening the cul-de-sac a quantity of serum escapes, which is a sufficient indication that the pelvis has been reached. This cavity can now be flushed with sterile water, as it is wiser not to use bichloride in the peritoneal cavity, then packed with gauze, the vagina packed, and patient placed in bed. It is only in exceedingly virulent cases, with the presence of pus-tubes or suppurative conditions, that this simple operation fails to cure the peritonitis, assuming, of course, that the endometritis has been overcome. We should not be satisfied with simply bringing our patients out of these various inflammatory conditions alive, but should endeavor most earnestly to bring them out *sound and well*; for to leave them bed-ridden invalids or suffering wrecks is scarcely more desirable than death. And the triumphs of recent medical and surgical science is that we can not only restore them sound and well, but we can take the hitherto abandoned wrecks and bring them back to life.

Such are the principal causes leading up to pelvic inflammations, and such is the treatment which has stood the test of the very worst cases, with results far beyond that which has yet been obtained by other methods; and not the least in its favor is the fact that it lies in the power of every intelligent, careful physician, specialist or not, to employ it.

THE SIGNIFICANCE OF INTERMITTENT FEVER.

BY F. MORTIMER LAWRENCE, M.D., PHILADELPHIA.

(An abstract of the concluding remarks at a medical conference held at the Hahnemann Hospital.)

GENTLEMEN: From the history of the case just presented we have learned that the patient, a railroad switchman, aged 36 years, was attacked by malaria while working in Atlanta, Georgia, seven years ago. The typical chill, fever and sweat occurred daily, but disappeared quickly under the administration of quinine by the physicians of a New Orleans hospital. From that time his health remained uniformly good until last July. Then, while at work in Mexico, daily chill and fever de-

veloped. He went to a hospital in San Antonio, Texas, and was discharged in two weeks apparently cured. A week later the paroxysms reappeared, however, and they seem to have been most irregular, occurring, he says, once or twice a day. The chill appeared in the later morning hours and the subsequent pyrexia lasted for about eight hours, *i.e.*, well into the evening. Vigorous dosing with quinine and calomel by the medical attendants of various Western institutions seems to have produced little effect. With the exception of an occasional intermission of a day or two he has had no relief; and finally, having drifted from Chicago to Philadelphia, he has been admitted to Hahnemann Hospital.

This is the case presented to you for diagnosis. If at first glance your problem seems a simple one, let me, nevertheless, beg of you to reserve judgment until every phase of the case has been discussed. To facilitate this we will consider it in the form of, not one, but three, questions:

I. Did this patient have a malarial fever?

You will notice that I do not use the word malaria without modification. Our later investigations have taught us that the term covers a group of fevers, differing from one another in periodicity as they differ in causative micro-organism; so that it is no longer enough to use the general term, and instead we speak of a quotidian, a tertian, a quartan or an estivo-autumnal malarial fever.

Now, what constitutes evidence of a past malarial infection of our patient? He tells us that he was in a malarial district, that there were many other cases about him. Were there many mosquitoes there? He smiles as he answers in the affirmative. A few years ago we, too, would have smiled at that question in connection with malaria; but now we know beyond doubt that malaria is conveyed generally, perhaps always, by certain varieties of the mosquito, and enters the human body through that insect's proboscis. Only in to-day's paper I read that some mosquitoes captured in the malarial Roman swamps had been transported to London and there permitted to bite a healthy man, and the latter developed typical malarial paroxysms. Nor is this all. Our present tendency is to a belief that the mosquito can acquire the infection only from man; but that remains to be proven.

At any rate, our patient has been exposed to malarial infection. Now let us inquire as to the periodicity of his chills. He says they occurred daily. This is not conclusive evidence as to the malarial nature of his attacks. Febrile paroxysms, at regular intervals of two or three days, are characteristic of no disease except malaria; but the attacks of chill, fever and sweat of daily or more frequent occurrence are similar to those accompanying many processes of a suppurative nature. Only the discovery of the organism in the blood can render positive our diagnosis in such cases. Our patient presents one bit of strong corroborative evidence, however, and that is an enlargement of his spleen. Percussion demonstrates an area of dullness in the left mid-axillary line, and extending well down under the ribs anteriorly. If we press with the left hand posteriorly and laterally over the splenic region while the patient draws a deep breath, the edge of the spleen can be felt readily by the fingers of the right hand pressed beneath the costal margin. Under the circumstances we need not hesitate to believe that our patient did have a quotidian malarial fever in July last.

This, however, serves only to bring us to a second question.

II. Has he a malarial fever at present?

Again let us appeal to our evidence. The chart shows that since he entered the hospital, ten days ago, the patient has had one paroxysm of what he calls "dumb ague," and his temperature on that day reached above 101° F. In the six days that have elapsed since then he has had a temperature about or even slightly below normal each morning, and every evening it has risen to a point slightly below 100° F. Can this be considered conclusive evidence of a malarial infection? Certainly it is not a quartan or a tertian fever, nor is it the type of a true quotidian. One form of malaria it might be—the estivo-autumnal. In temperate climates, during the autumn months, malarial infections are observed which present many irregularities of onset and recurrence. The three classical stages of the paroxysm are absent or modified, and the parasites in the blood differ from the tertian and quartan forms. Are we justified in believing our patient to be suffering from this form of malaria?

Gentlemen, the positive diagnosis of malaria in any form can be made only by demonstration of the organism in the blood.

The technique of such an examination is not difficult. Spread a drop of fresh blood on a slide, and while you are examining that allow a few cover-glass films to harden in alcohol and ether. If your search has not been successful in the fresh specimen, stain your films with methylene blue or hematoxylin and eosin, and search again. The plasmodia are found within the red corpuscles, sometimes in quite large numbers, a short while before the paroxysm, disappearing during the remission. A failure to discover the organism on the first slide examined is not sufficient for a negative decision, however. A patient search, extending over several slides, and occupying in each case half an hour or more, is essential to a final conclusion.

In the case of this patient we have made repeated examinations of blood-specimens taken at various periods, but without discovering any form of the parasite. Perhaps we should have followed Osler's advice and punctured the spleen. The procedure is free from danger if properly done, but we felt that unless absolutely essential to a differential diagnosis it should be omitted. A blood-count has been made. Could we demonstrate an increase in number of the white corpuscles, a leucocytosis, we would know that malaria, if present at all, is not uncomplicated. But instead of an increase we find the white corpuscles, which you remember average between 5000 and 10,000 in health, are reduced to about 3700 in the cubic millimeter; and the number of red corpuscles is reduced proportionately. In other words, we find an anæmia of secondary type. This condition is found in protracted malarías frequently, and it occurs also in acute infections, such as typhoid, measles and tuberculosis.

What, then, can be our answer to the second question? It must, I fear, be the old Scotch verdict of "not proven."

III. If the fever is not malarial, what is it?

All diagnoses are, to some extent, by exclusion. In our present quandary let us apply this method, basing it upon the symptoms presented by our patient. Does any infection other than malaria present such a temperature range as this, normal or subnormal in the morning, with slight evening pyrexia?

It is not typhoid; in the ten days that have elapsed since the patient entered our wards the temperature would have risen, or gastro-intestinal symptoms would have developed, or the typical

rash would have appeared. Is it pneumonia or influenza? Neither of these could be protracted so long without the appearance of some characteristic symptoms. Is it ulcerative endocarditis? Auscultation of his heart reveals no evidence of its involvement. Can there be an internal suppuration? No, for in that case local pain and physical signs would have appeared before this. Only one other disease that presents such a febrile movement remains unmentioned, and that is tuberculosis.

Now let us recall this man's symptoms, and in addition ask him one or two questions. Has he lost flesh? Yes; forty pounds in three months. Does he cough? He answers in the negative, but while undergoing examination he has coughed in a slight hacking fashion several times. Let us examine his lungs carefully. Listening over the right infra-clavicular region, and again posteriorly over the right apex, we note that the expiratory sound is unduly prolonged, so that it is quite as long as that of inspiration, and it is higher in pitch. In other words, we find broncho-vesicular breathing. It is a circumscribed area, and there are no râles. Yet, under the circumstances, our diagnosis need remain in doubt no longer. This man is the victim of a beginning tuberculous process, probably an infection due to his weakened resistance after a protracted malarial siege.

Gentlemen, one lesson is to be learned from this case—take nothing for granted. Prove every point in a diagnosis. Many cases like this are diagnosed as malaria or typhoid fever by physicians more careless than ignorant. Thayer says that every case of phthisis developing in the South is treated for malaria at some period of the disease. Be on guard against such a mistake, for it is in the early stage, and only then, that tuberculosis is a curable disease.

ALCOHOL COMPRESSES FOR PERITONITIS. SEHAWALD.—The writer tried this in a case suffering from severe peritoneal symptoms, vomiting and pain, in whom ice pills, ice bags and opiates did not benefit. A sheet of rubber dam was applied outside of the alcohol compress to increase the irritation of the skin, and outside of this cool, wet compresses. The vomiting ceased during the day, and the patient rapidly recovered.—*Centralblatt für Gynäkologie*, No. 38, 1900.

IS THE SEPARATE EXISTENCE OF THE HOMŒOPATHIC SCHOOL STILL
A NECESSITY?

BY J. H. MCCLELLAND, M.D., PITTSBURGH.

(Address at the Jubilee Meeting of the Homœopathic Medical Society of the State of New York.)

THIS rather leading question, given me for brief discussion, cannot with propriety be answered with a single affirmative or negative.

It is indeed fraught with momentous consequences to a large body of reputable and admittedly ethical practitioners of medicine, and perhaps with still more serious consequences to the sick for all time.

Homœopathy is an organic entity ; logical, symmetrical, and of proven efficiency in the treatment of the sick. As immediate and remote consequences of its introduction into the science and art of medicine, it has been the cause of most radical, far-reaching and beneficent changes in the practice of the Healing Art. It is only necessary to refer to the utterances of many honorable and fair-minded men of the dominant school in proof of this. For example, Sir John Forbes, in speaking of Hahnemann, proclaims him as "one whose name will descend to posterity as the exclusive excogitator and founder of an original system of medicine as ingenious as any that preceded it, and probably destined to be the remote if not the immediate cause of more changes in the practice of the healing art than have resulted from any promulgated since the days of Galen himself." Could anything be more pointed, more sweeping, and withal more true than this manly declaration from an eminent authority of the Old School?

It is not too much, therefore, to claim that the high mission of homœopathy has been to rescue medicine from the degradation of empiricism and mysticism which marked the practice of even its most eminent professors.

It remained for Hahnemann to lay his hand of steel upon the homicidal hypotheses of the day, and in the name of science appeal to truth and reason.

The want of a therapeutic system before Hahnemann's time gave full scope to individual notionalism, and the rank and file of the profession slavishly followed such empirical methods as were given prominence by the leaders of the day. Brunonianism, Cullenism, Broussaisism and more of the like ruled the hour, and the schools talked of Hippocrates, Galen and Celsus as if medicine had made no appreciable advance since their day, which was very near the truth. The most monstrous iniquities of medical practice then passed current as scientific.

It was at this point that Hahnemann stepped forth, and single-handed took up the gage of battle against the Philistian giant of medical error. It was indeed an ungracious task, and he was never quite forgiven by the reigning medical powers,—nor indeed has he yet been by their successors.

Howbeit, the world was saved much slaughter of the innocents, and was given a benign and scientific system of healing instead of the uncertainties of empiricism.

Is it not true that Homœopathy, of all the systems of medicine since recorded time, has alone survived a hundred years? Is it not true that one generation after another has spent its time in showing the fallacies of the previous one, and explaining how immensely improved and scientific is the present over the past?

Sydenham did much to reclaim medicine from the brutal methods of the sixteenth century, which, under the sanguinary lead of the Piedmontese Botal, bled the human race, sick or well, to the point of syncope. The sick were bled as a matter of course, and the well were bled, forsooth, to keep them from getting sick. But even the gentle Sydenham only revived the less destructive methods of our ancient progenitor, Hippocrates.

I refer to these things to remind the forgetful of the mighty service Hahnemann rendered to mankind in exposing and overturning these pernicious methods of medical practice, a service which should never be forgotten by friend or foe.

We do not pretend that in the presence of the widespread intelligence of the nineteenth century these absurd and vicious methods would be tolerated, but even now there is no abiding principle in the practice of medicine, save the one given us by Hahnemann. Bacteriology has indeed opened up new and more promising fields, and serum therapy (which is in truth a

modified homœopathy) has scored some triumphs; but the great and notable fact remains that medicine, with the one exception mentioned, in the last half century has never been more than a decade the same, so rapidly does the new become the old.

As one consequence of this, the laboratory has been worked double turn, and ever and anon evolves therapeutic novelties for the medical practitioner, who verily must yield the palm to the pharmaceutical chemist.

Is, then, the time ripe to answer in the negative the question that is the subject of my theme? Admitting the desirability of a unified profession, and how pleasant it would be for "brethren to dwell together in unity," can we at this time affirm that the separate existence of the homœopathic school has fulfilled its mission, and that now we should take down our distinctive title and be engulfed by the old-school profession?

On the contrary, it seems but reasonable that if homœopathy is founded upon scientific principles, and gives evidence of growth and stability, it may, with becoming propriety, claim the right to pursue its mission in relieving suffering and saving life. Upon this point one may find much interesting and instructive matter in the readily accessible records of our school as set forth from year to year in the *Transactions of the American Institute* and elsewhere. Especially is this the case in the report submitted by Dr. Geo. B. Peck to the International Congress, printed in the HAHNEMANNIAN MONTHLY for September, 1900.

In this admirable paper we find an extraordinary array of statistics showing the marvelous advances made by homœopathic institutions, societies, colleges and journals during the last five years. This paper will well repay perusal, and it is not an exhibition of waning power or popularity.

Finally, we claim, in the words of the immortal Dunham, that "Homœopathy is the science of therapeutics."

According to the teachings of its founder, Homœopathy is based upon three generalizations:

1. A rule of practice which is of univereal applicability—so far as medicinal agents are concerned.

2. The practical application of this rule is made possible by the methods of ascertaining the therapeutic range of drugs by provings on healthy human beings; a method which Hahnemann introduced in a practical way to the scientific world.

3. The method of increasing the medicinal value of drugs by trituration and diffusion, *i.e.*, dilution. This pharmaceutical generalization is of the utmost therapeutic value.

Under the first we fling to the breeze the great therapeutic generalization *Similia similibus curentur*—founded, as we firmly believe, on nature's own law of drug affinity. In this connection I take the liberty of quoting from the above-mentioned paper of Dr. Peck the following interesting comments: "Very important were the considerations that prompted the American Institute of Homœopathy, at the session of 1899, to change the motto on its seal from *Similia similibus curantur* to *Similia similibus curentur*. By that act a general statement of fact, to which no one could justly take offense or even exception, was transformed into a direct positive command. No more important, no more significant procedure has occurred during its entire history; and yet very few comprehended on that day, if, indeed, they now understand, the full import of their vote—the Institute is made boldly to proclaim to all the world that thus, and thus only, can health be restored promptly, safely, permanently. Adventitious though this action was, the trend of events during the past twenty-one years indicates its timeliness. With malice toward none, but charity for all, the Institute now stands the exponent of pure homœopathy. Should she ever prove recreant to her pledge, she will have already pilloried herself to her eternal shame." Nor am I sorry for the share I took in securing this important piece of legislation.

The second generalization is of the utmost importance to the practice of therapeutics. It is the method of ascertaining, in a scientific way, for therapeutic purposes, the exact effect of drugs on the healthy human organism. This is now recognized by all authorities on the subject as the only correct method.

The value of the third generalization, *i.e.*, that subdivision increases the medicinal quality of drugs, is admitted by the majority of scientific investigators, and is generally practiced in both schools.

What then? With societies well organized, with an increasing literature, with colleges flourishing and leading the whole profession in the contest for higher medical attainments, with a united profession thoroughly educated and ethical, is this the time to abandon our name and fame and opportunities for ex-

tended usefulness in the world of science? We unhesitatingly answer, *No!* The Homœopathic school, as a distinct but not antagonistic organization, still has an exalted mission to fulfill in the special field of therapeutics.

HYSTERICAL ANURIA.

BY W. F. BAKER, M.D., PHILADELPHIA.

ANURIA is a term applied to a complete cessation of the urinary flow. It is used in contradistinction to ischuria, a term applied to a very marked decrease in the secretion. Either of these conditions may be due to organic disease of the heart or kidney, or they may be purely functional. Where there is a cessation which is purely functional in character, we know it by the term hysterical anuria.

While anuria is in the greater number of cases the result of organic disease and significant of danger, yet it may be a pure neurosis and of passing moment only. In the absence of any evidence suggesting an organic lesion and all our investigation proving negative in its results, we should look on the case as one of hysteria. And especially if we find in association with the anuria other stigmata, such as disturbances of sensation, increased reflexes, concentric contraction of the visual field, etc., can our diagnosis be confirmed. It is important that we should arrive at the diagnosis of hysteria last, and then only after painstaking investigation, and the exclusion of organic diseases, one by one, as they are suggested by the symptoms.

As to the cause. In the normal action of the gland the relationship of the neurons one to the other is preserved. In a functional disturbance such as we have in this case, that normal relationship has been broken. There has been a break in the neuron circuit. The axon bringing the impulse to the cell has not made its proper connection, but may have reached some other portion of the lower neuron, and the result is a disturbed action, or a complete cessation of function. As soon as that relationship is again established, the function is fully restored. The vaso-motor system is the system most affected. These reflex actions are, as a rule, the result of emotion.

The result of emotion on glandular secretion is known to all; for instance, the sudden disappearance of the saliva from the mouth in those affected with "stage fright," leaving the mouth dry and parched. Also note how frequently a wholesome meal is made to act as an irritant by reason of the suppression of the gastric juice following some sharp words spoken at the table.

Any mental impression acts first on the hemispheres; and a reflex action, starting in the medulla, extends through the cord to the vaso-motor nerves, and thence to the sympathetic fibres of the renal plexus. Instead, this reflex action, carried by the axon, reaches the disordered connection, and the loss of function or its perversion is made manifest.

As an example of hysterical effect on the vessels, which has been observed, Pepper cites a case. In this instance there existed a hemianæsthesia dependent upon hysteria, and ophthalmoscopic examination revealed the retinal vessels on the affected side reduced to one-third the calibre, of those on the sound side. We may assume, then, that in anuria there is an anæmia of the kidney, and a consequent loss of function, just as there is a functionless brain in sleep, as sleep is the result of breaking of the connection of the neurons.

Urinary Examinations.—In some cases no change is discoverable, while in others there is a reduction in the output of urea. Attending this condition there is usually vomiting, and an examination of the ejecta will show the presence of a corresponding amount of urea. There is also a close relation between the amount of vomiting and excretion of urea. The phosphates are reduced to about one-half, and the relation of the earthy to the alkaline is altered.

Case.—Married woman, age 26 years, who had been under heavy emotional strain following an incomplete abortion, had become worried about the repeated attacks of hæmorrhage through which she had lost a great amount of blood. Curettement was advised, and recovery seemed complete. Some weeks later I was summoned, and on my arrival was informed that in the previous twenty-four hours she had passed but a few drops of urine. By previous examinations I knew that the urine was normal, and was at a loss to account for the phenomena. She was catheterized, and but a few drops were obtained. Hydro-nephrosis was thought of, but no evidence to justify that diagnosis.

Liquid food was advised, together with a hot pack, and the administration of calomel. Notwithstanding these measures, which aimed to increase the excretion of urine, on four succeeding days there was a complete cessation of the secretion.

It is interesting to note the symptoms present during the period of suppression. They were all of a hysterical order, including exquisite skin tenderness, so that when touched she would flinch, globus hystericus, tachycardia, dyspnœa, concentric contraction of the visual field, and repeated hysteroid convulsions. Day after day went by, and at no time during that period did she pass over one to two drachms in the course of twenty-four hours.

Summing up the kidney action then for the time she was affected, we can say that there was complete cessation for four days, and for eight days longer the total quantity was less than two and a half ounces. I was at a loss to know what to do, and the patient, who was conversant with some few things in medicine, was sure she could not live. Finally resort was had to hypnotic suggestion, under the influence of which she readily yielded, and the kidney function returned to normal in a few days. An attack of retention followed some little time after, and catheter gave relief. The patient has been in good health ever since, a period of nearly a year.

SPASMODIC WRY-NECK AND ITS TREATMENT.—It has been known that clonic spasm of the sterno-mastoid of the spasmodic variety has been looked upon as being very intractable to treatment. Its nature has been considered as analogous to writer's cramp. The attacks come on with varying severity and frequency, in which the head is usually drawn to one side. There is sometimes hypertrophy of the muscle that is constantly called into overaction. Considerable pain is at times experienced at the insertion of the muscle. A tremor of the head, due to the attempt to correct the spasm, is seen at times. General symptoms are those of neurasthenia and hysteria.

As to treatment. The principal therapeutic agent has been massage of the affected muscles. Methodical education of the muscles and their coördinating centres is advised. Atropine, hypodermatically used, is said to be the best medicine in doses of $\frac{1}{200}$ of a grain, repeated daily, and its effects watched until there is a cessation of the paroxysms. The atropine was injected into the body of the affected muscle.

Surgical means are advised after these fail. The resection of the spinal accessory or cervical nerves has met with large success in selected cases.—*New York Med. Journ.*, Nov. 24, 1900.

EDITORIAL.

EDUCATIONAL METHODS IN MEDICAL COLLEGES.

THE special monthly number of the *Philadelphia Medical Journal*, September 1, 1900, on "Medical Education," must have aroused great interest in all those who have given any attention to the subject of the elevation of the standard of medical education in America. It is a subject which concerns directly or indirectly not only the public at large, but every practitioner of medicine.

The *Journal* presented original articles on the teaching of Physiology, of Pharmacology, of Materia Medica and Therapeutics, of Gynæcology, of Physiological Chemistry, of Obstetrics, of Pathology, of Hygiene, of Anatomy, and of State Medicine, with two other related articles on "The Master of Medicine as the Teacher of Medicine," and "The Relation of Comparative Pathology and Biology to Medicine." With the exception of the last, all the articles are by professors in medical schools connected with universities, either State institutions or such as are largely endowed. We draw especial attention to this fact because it naturally influences both the conception of the objects of such teaching and the methods to be employed. They all describe such methods of teaching as impress by the ideals they hold up, and it is not at all impossible that many readers have been inclined to draw comparisons between the methods there advocated and those employed in medical colleges—to the disadvantage of the latter.

It would manifestly be impossible for us to review all or any of these articles in the limited space at our command; we will be compelled to rest content with a presentation of what we regard as the fundamental principle which must guide us in estimating their force as applied to medical colleges.

The relation to knowledge as a whole held by a university, if it attempts to be such in deed and not in name only, is an entirely different one from that held by a college, be it com-

mercial, classical or medical; and the medical department of a university cannot be regarded as exactly similar to a medical college, or even as its equivalent.

The university has for its ideal aim the presentation of all science, all art, and all arts. Its scope cannot be too wide, its researches too deep, or its teachings too widely removed from those of the bread-and-butter sciences (*Brod-und-Butter Wissenschaften*) of the independent college. The medical school of such an institution, being an integral part of it, must have the same ideal aim, the same limitless scope, and consequently the same general methods of teaching. It has, or should have, its object within itself. There should be no thought either in the number or character of the subjects presented, or in the manner of their presentation, but depth, thoroughness and exhaustive treatment. The pursuit of knowledge for its own sake must be the characteristic of the university in all its departments; therefore, also, of its medical school.

With the medical college the case is quite a different one. There is here a definite, clearly-expressed object, viz., the furnishing of a medical education which shall enable its possessor to practice medicine and surgery, and to furnish this in as direct and practical a manner as possible, consistent with necessary thoroughness and correctness. The thoroughness and correctness here aimed at are limited by the practical end in view, for here medicine as taught must of necessity be treated as a bread-and-butter science, and information may well take the place of knowledge. We consider it, therefore, just as illogical for a medical college to attempt to teach medicine, from a university point of view, as for the medical school of a university to make concessions to the practical demands of those desiring to study medicine in order to practice it. The teachings of the university medical school belong to those who have passed through a medical college as a post-graduate course, to be pursued only by those to whom the direct practical is a secondary consideration.

To show that this is the only consistent and correct view, and one actually held by university teachers, at the same time that we may be enabled to contrast their aim with that which all consider the "paramount issue" in a medical college, we will quote from the article on "The Teaching of Physiology," by Prof. Porter of the Harvard Medical School.

He opens by saying, "To the physician the study of physiology is of use largely because it creates a habit of thought essential to the highest professional success." If he really means the physician *in re*, and not *in spe*, we can agree with him; but he seems to have in his mind the prospective physician, since a little further on he continues: "The getting of mere information wastes the student's time."

"The student should come to the lecture already possessed by his own efforts (in the laboratory) of the phenomena to be discussed." It is manifestly impossible for the student to have gained in this way all the phenomena to be discussed, since, according to the professor's own acknowledgment, "No one in these days can work profitably in many fields. A man trained in the physiology of digestion is likely to have but a feeble grasp of the circulation, the nervous system, or the special senses." "It would be idle to expect the student to get a personal experimental knowledge of the whole subject. His limited time must be used for training, and not chiefly for the acquisition of facts, as at present." "Medical training should be 'for power,' and only secondarily for information." Considering that the majority of medical students in a medical college are in attendance in order to learn facts, and principally only such facts as shall be of practical use in the subsequent pursuit of their profession, it surely would be improper to shape the methods of instruction to them by these principles. Where in later years one student finds at his command time, means and inclination to pursue unpractical investigations, there are at least fifty who are obliged, and probably content, to limit their further study to the acquisition of facts at second hand by reading current medical literature.

Prof. Porter, recognizing the impossibility of teaching even the cleverest student all things, advocates an early election of a specialty, and says that even "In anatomy, physiology and pathology the student should spend his time in those particular portions which are directly associated with his future work as practitioner or investigator. The medical degree, at present, is granted for superficial information in 25 or 30 subjects. The sign of the scholar and scientist, namely, thorough knowledge of some one field, is wanting."—"A further necessity for election is seen in the fact that the great medical schools are

university departments. They are attended by an increasing number of men who will never practice medicine, but will become investigators in some branch of biological science."—In this last, we think, lies the fundamental principle of university educational methods, and we regard it as an illogical departure from this when the professor, in speaking of his own department, says: "To meet the needs of the several classes of medical students found in universities, the department of Physiology must provide: 1. A primary course suitable for every student of biological science, including medicine; 2. An advanced course, intermediate between the primary course and research; 3. Opportunities for physiological research."

From these quotations we think it is evident that the point of view of the medical department of a university differs essentially from that of a medical college, and that the methods of the one cannot and ought not to be applied to the other. In both, the laboratory has come to occupy a most important place, formerly unheard and undreamed of. In the university, however, it is to provide opportunities for original research, and to form the basis upon which the lecturer then builds, while in the college, according to our view, it serves merely to corroborate the statements of the lecturer, and, by an appeal to visual memory, to impress the most important practical facts. In both, interest in such investigations should be aroused and cultivated,—in the university course as a primary object, in the college as secondary.

Again, as to the early election of a specialist, an honest but very decided difference of opinion exists. In the college such election is altogether out of place; in the university, considered as a post-graduate school, it is eminently logical and necessary. How can the ordinary college student, unacquainted with the field, make a selection of that portion which is best suited to his tastes and talents? And yet a selection based upon these can alone furnish the motive and incentive for enthusiastic lifelong work. The specialist should have first been a general practitioner, and such it is the province of the medical college to turn out,—not "scholars and scientists." After having obtained a general knowledge of medicine, and after having tested for a reasonable time his own capabilities and inclinations, the general practitioner will be in a condition intel-

ligently to adopt a specialty as his life-work, and can then turn to those institutions where he can obtain the most thorough instruction. His hitherto dissipated but not wasted energies will then be concentrated upon one object, and we can reasonably demand of him a thorough acquaintance with and devotion to it. The medical college cannot, in justice to the majority of its students, be expected to furnish him with facilities for doing this, except in an imperfect way, in its own post-graduate course. The college must have a fixed curriculum through which all its students must work their way. A university should have no curriculum; each student must make his own, by his choice from the studies which are presented to all.

If we are compelled to reject his suggestion of early selection of special study, we most heartily agree with Prof. Porter that in regulating studies, even in a medical college, more regard could and should be had to the principles of concentration and sequence. The logical sequence of studies should be respected as much as possible, so that each one should be built upon knowledge already acquired, and the smallest possible number of subjects should be presented at any one time, in order that the mental energy of the student should be concentrated upon them. In passing from one to the other of numerous subjects, as is too often the case at present, there is each time a certain amount of mental *vis inertiae* to be overcome before the train of thought can move in the now desired direction. This involves a loss of energy which could be more usefully employed in the continuance of the same object of study for a longer period at one time.

The sum of the whole matter then is this, that while the methods of instruction in medical colleges are capable of improvement, particularly in the direction of concentration of effort on the part of the student and more logical sequence of the studies as taught, these methods should not be modelled after those of the medical department of a university; that while thoroughness is to be aimed at, this thoroughness should be in the direct practical application of scientific knowledge; that, therefore, no attempt should be made to turn out scholars and scientists, but well educated (medically) general practitioners. This latter its graduates must be; the former they may hereafter become—*Deo volente!*

BUSINESS ENTERPRISE AND THE PHYSICIAN'S DOLLARS.

BUSINESS enterprise is ever alert for new methods by which the "almighty dollar" may be coaxed to enter the treasury of those with inventive faculties. It is not intended to infer that new business methods are by any means illegal, for, as a matter of fact, such is not the case, but rather that their success depends very largely upon the unsuspecting temperament of the proposed patron, or had we better say "victim"? We have been led to pen the above remarks because of a recently devised scheme for taking money from the pockets of the unwary, said scheme finding many imitators and bidding fair to become popular in the business world, especially that part of it having to deal with physicians and other professional men. Variations are made from time to time, but the scheme is essentially the same, no matter how it may be worked.

The victim receives a circular letter, in which it is broadly stated (or simply inferred) that his very valuable influence is wanted in placing a certain work before the public. The publisher being very honorable, and therefore unwilling to receive favors without extending the same, expresses himself as anxious to make a confidential offer, which he is sure will inure greatly to the advantage of his medical victim. The latter replies on the enclosed postal card that he will be pleased to have said advantageous offer submitted to him. In reply he is told "that our Mr. — will shortly visit your hospitable (*sic*) city, and will take great pleasure in calling upon you." Mr. — calls, and brings with him an accomplice—no, we mean business associate. The victim is then told of a valuable series of books prepared under the supervision of the eminent Professor — for a certain definite purpose. These books were never intended for sale. They were published for the good of humanity only. Indeed, they are so very valuable that it is a sin and a shame that their circulation should be limited to any clique of humanity. So the author kindly consents that numerous human victims shall drink of the knowledge that its pages afford, and now the work is offered to a certain favored few at

the mere cost of binding. Examination of the work and a knowledge of the book business tell us that the price asked, though apparently cheap, is in reality about four times the cost of binding. Those who are privileged to subscribe are selected with great care; indeed, New York is limited to 30 copies, Philadelphia to 20, etc., etc. One would think that such a scheme as this is so transparently "fakish" that no victims would be found. And yet it was worked the country over.

A later variation starts as before with the confidential offer. The conspirators call. We are told that the book is not to go on sale for a year to come; in fact, no amount of wealth can procure a copy except in a certain way, which is as follows: 30 copies have been allotted to your city. But 50 physicians out of your 2500 will be permitted to make offers or bids for the set of books; the 30 bidding the highest are accepted as customers.

The books arrive; and what are they? Old editions worked up; printed on old plates; wood-cuts executed before the Civil War. But what of the binding? That is all right, the only thing in the job that is according to contract.

The confidential-offer scheme is now being attempted about once a week; on an average. Its success depends upon the weakness and unsuspecting character of human nature; the weakness is vanity, and the unsuspecting character is what we find among physicians generally.

The directory and biography scheme is another money-coining device against which we should all act. No matter what the titles of such works may be, no matter who may be the promoter, it is an incontrovertible fact *that it is cold cash, and not pre-eminence in one's profession*, that secures notice in their pages. Respectable physicians who are deluded into subscribing find their portraits in company with nostrum-venders, saloon-keepers, jail-birds, politicians of all grades, and of some few well-meaning people who have a strong penchant for seeing their names in print and their physiognomies on paper. Exceptionally we note the biography and portrait of a man of eminence who has been induced to enter the scheme without paying out money, the idea in treating him thus generously being to secure more of the unwary. If the eminent Prof. — is in, why should we not go in also? And in we go. The eminent gentle-

man who enters is probably the greatest criminal of all, for he permits himself to be used as a cat's-paw to pull the biographer's chestnuts out of the fire.

In dealing with all such schemes, one should remember that the only business propositions worth considering are those of a straightforward character; those which come to us openly with a direct offer of so much return for so much money. Under no circumstances should we pay for privileges or favor by the use of our good names, for that is, in the majority of cases, the only capital of the hard-working professional man. When he has lost that, and the respect and esteem of his colleagues, he is poor indeed. It should never be used in lieu of cash.

WHOOPIING-COUGH.—The opening sentence of the paper upon this subject, written by J. Roberson Day, of London, is enough to key the interest of the reader to the highest pitch. "Homœopathy can do so much for whooping-cough that it is always a pleasure to treat these cases." The author further along makes the positive statement that, "as soon as treatment is commenced, amelioration of symptoms is marked and rapid, the number of spasmodic coughs is lessened, and the severity of each attack is also less." Dr. Day bases these statements upon a large experience with the disease under consideration in private practice and in hospital work. The method of treatment which he recommends, and which has been so satisfactory, might be described as reinforced homœopathic treatment; that is, the application of the homœopathic remedy or remedies, reinforced by various adjuvants.

Drosera, he says, [is our sheet-anchor. It must, however, be given in a high dilution (preferably the 30th). When given in the tincture it is useless.

Passiflora incarnata is of great value to relieve the night attacks; it lessens their violence and induces sleep. Hence the author of the paper is fond of giving *drosera* 30 and *passiflora* during the night. He also has been in the habit of prescribing a liniment composed of ol. succini, 2 drs.; ol. carpophylli, 2 drs.; ol. olivæ, 4 drs. This he recommends to be rubbed into the chest, and especially down the spine. In addition to this, he lays stress upon the importance of light, easily digested food in small quantities and at frequent intervals. Large meals may, in serious cases, increase the tendency to vomiting. Many other remedies are required, says the author, from time to time in the course of the disease. Thirteen selected cases are then given by way of illustration, which, unfortunately, do not prove conclusively that the results of the method are exceptionally brilliant. The remedies used in addition to those mentioned were acon., ant., bell., china, corall., hep., hyos., ipecac., puls. The predominant treatment was, however, *drosera* 30, with *passiflora* at night, and the amber oil inunctions as described.—*The Monthly Homœopathic Review*, December, 1900.

GLEANINGS.

DIPHThERITIC PARALYSIS AND ANTITOXIN.—The investigation into this subject was brought about by the statements of some that diphtherial paralyses were far more frequent since the introduction of antitoxin. The results of investigation are as follows: Paralysis is to be expected after the injection of one-fourth the minimum lethal dose of the diphtheria toxin; after one-half it always occurs; doses below one-fourth may cause paralysis, but not constantly, and below one-eighth it was not produced.

Neutralized mixtures of toxin and antitoxin do not cause paralysis, but when the mixture contains a deficiency of antitoxin paralyses do occur, and in direct proportion to the discrepancy.

When the antitoxin is administered 15 to 22 hours after intoxication, even the largest doses do not, with certainty, prevent paralysis, where the dose of toxin approaches the minimum lethal dose.

With increased doses of antitoxin the paralysis decreases in severity. Small doses of antitoxin have no effect in diminishing the paralysis. From these facts we may learn a few ideas as to the administration of antitoxin.

Large doses, if given early, should prevent paralyses, especially those of the heart. If paralysis is more often noted in these days it must be due to the fact that many of the severe cases are rescued by antitoxin which, without it, would have died. Severe cases are liable to paralysis, even if antitoxin be used.—*Journ. of Path.*, vol. vi., No. 4.

William F. Baker, A.M., M.D.

THE LEUCOCYTE COUNT IN PLEURISY.—This was observed in twenty cases of serous pleurisy. These cases were all primary, and not secondary to any acute pulmonary disease. The object of the count was to find out if there was anything in the white count that could be of any practical value in the diagnosis, or if any information could be learned as to the progress of the exudate. Two hundred and twenty-four counts were made in all. The results ranged from 3000 to 14,000, and, accepting 10,000 as the maximum normal number, only 13 counts showed an increase above the normal. Nine of these counts were made from one case, which showed on autopsy a secondary pneumococcus infection.

These results agree with those of Cabot, and the conclusion is justifiable that there is not a leucocytosis in serous pleurisy.

Nine of the cases were tubercular, but in no one of these, save the one of pneumococcus infection, was the count over 10,000.

Relation of the white count to the duration of the illness could not be ascertained.

It was also ascertained that the course of the fever had no relation to the white corpuscle count.

Conclusions reached from these cases are: (1) Serous pleurisy is exceptionally diagnosed by the leucocyte count; if the physical signs are doubtful and

there is no leucocytosis the condition is not pneumonia or empyema, but serous pleurisy; (2) if there is a serous pleurisy and a continuous leucocytosis, then some complication exists.—*Am. Journ. Med. Sciences*, December, 1900.

William F. Baker, A.M., M.D.

TREATMENT OF INOPERABLE CANCERS.—Czerny thinks this matter should be given more attention. He says it is very unfortunate that medical men as soon as a case is pronounced inoperable lose all interest in the case.

Profuse discharge and bleeding may be checked and severe pain controlled by cautery, caustics and sharp spoon curettement.

Formalin in 10 to 40 per cent. solutions is recommended as a good application to an ichorous and hæmorrhagic ulcer. In the local treatment of open inflamed cancers the use of antiseptic dusting powders, as boric acid, soda salicylate, iodoform, orthoform, is indispensable.

He also mentions the production of an artificial erysipelas for the cure of sarcoma.—*Centrallbl. f. Chir.*, Nov. 28, 1900.

William F. Baker, A.M., M.D.

THE ESSENTIAL FEATURES OF HYDROTHERAPY AS APPLIED TO PULMONARY TUBERCULOSIS may be summarized: General and local cold applications to the skin, carefully applied, taking into account the patient's condition and his ability to react. The best means of doing this is by dry friction, wet hand rubbing, wet mitten friction, cold towel rubbing, general bath.

The application of compresses hot and cold as a means of relieving pain and controlling local blood supply, especially the use of the chest pack to relieve the cough.

By hydrotherapy we are able to exaggerate and diminish impulses sent inward from the skin, and thus control nearly all the bodily functions to a marked degree. At least the vascular tone is maintained. A change of climate is deemed advisable with this treatment.—*Med. News*, Nov. 24, 1900.

William F. Baker, A.M., M.D.

HEROIN AS AN ANALGESIC.—Heroin or heroin hydrochlorate has been advanced of late for its power of allaying cough and dyspnoea and of its antispasmodic effect. It has been of most value in the treatment of phthisis, bronchitis, laryngitis, asthma, hay fever, whooping cough. It is usually used in doses of $\frac{1}{12}$ to $\frac{1}{24}$ grain, but at times it is necessary to use larger doses. It is well tolerated when given in gradually increasing doses. Toxic effects in any cases have not been seen by the writer, and the heart has not been depressed. As a sleep producer it acts well. For the restless sleep of phthisis it acts well in doses of $\frac{1}{12}$ gr. given at bedtime. If the drug is to be repeated every night, it is well to follow the usual dose by $\frac{1}{24}$ gr. one hour later. In persistent insomnia of neurotics or in acute illness it is highly recommended. It is claimed to have a good effect on repeated epileptic attacks, and in this use it is usually combined with chloral. Hysterical attacks are shortened by its use. In neuralgia in combination with some of the coal tar derivatives it is highly recommended. For the pain of cancer it has shown itself as good as morphia and without its bad effects.—*N. Y. Med. Journ.*, Dec. 1, 1900.

William F. Baker, A.M., M.D.

CORTICAL LOCALIZATION OF SIGHT AND HEARING.—To determine the localization of any function it is necessary to study the effect of irritation and

destruction of the supposed centre in animals. The study of these in man must be confined to diseased processes and their post-mortem appearances.

In experimenting on monkeys it was found that electrical stimulation of the cortical portion of the occipital lobe (mesial and under surface) produced conjugate deviation of head and eyes to the opposite side. It has been regarded for a long time that the regions where such motions lie are related to the sense of sight.

The whole visual area of one hemisphere is connected with a corresponding portion of the retina, for it was found that by irritation of the angular gyrus similar results were obtained, and this was interpreted as meaning that a connection existed between the cerebral visual area and the retina.

Destruction of this gyrus produced hemianopsia, and thus it is thought that lesions of sight occur from lesions of the angular gyrus rather than from extensive lesions of the occipital lobes.

Concerning the cortical localization of hearing, it was found that on stimulating the upper two-thirds of the superior temporal convolution in monkeys there occurred a quick retraction of the ears and the turning of the head to that side as if in search of some sound. Destruction of that area resulted in a loss of hearing, but excision of other parts of the lobe were negative in results as to hearing.

A case of sudden apoplectic seizure resulting in a loss of hearing, on autopsy one year later, showed atrophy of the superior temporal convolution.

Another case is reported in which, during the first apoplectic seizure, there was word deafness, and in the next apoplectic attack the patient was rendered totally deaf, and autopsy showed the superior temporal convolution atrophic on the left side, while on the right side there was an old hæmorrhagic cyst destroying the first and second temporal convolutions, insula, and internal capsule.

The following conclusions are then drawn: (a) The centre for word hearing is situated in the hinder thirds of the first and second temporal convolutions; possibly it is restricted to the second; (b) a lesion confined to the posterior thirds of the first and second temporal convolution of the left hemisphere will produce complete word deafness; (c) the field for all auditory memories covers a larger cortical area than that for word hearing, including at least the posterior thirds of the first and second temporal convolutions.—*Amer. Journ. of Med. Sciences*, Dec., 1900.

William F. Baker, A.M., M.D.

POST-OPERATIVE DELIRIUM IN OPHTHALMOLOGY.—Fromaget adds two cases of this condition to the recorded list of post-operative delirium. They were both in old men. In each instance the patient suffered from marked reduction in the amount of urine daily passed, as well as from constipation. In one case the delirium disappeared under a very restricted diet in combination with the exhibition of purgatives. The other one became much better under this treatment, but he never recovered, dying from uræmia about two months later.

The author calls attention to the rôle played by auto-intoxication in these cases, and suggests that the great number of similar attacks could probably be traced to the same cause. The very fact of the extreme age at which patients are generally operated upon for cataract is in itself, he says, a source

of constant danger of break-down of the excretory organs. As to the occlusion of the eyes entering in as an etiological factor, he believes that it acts simply by inducing sleep, during which condition the patient has dreams, these passing into delirium. That this may be the case, he believes has been proven by neurologists. The emotion and excitement, the confinement to bed and the change in diet, all of which have been brought forward as causes of the disease, he thinks, probably constitute factors in nutritional disturbance. —*Annals d' Oculistique.*

William Spencer, M.D.

A CASE OF RETARDED CICATRIZATION OF THE CORNEAL WOUND FOLLOWING CATARACT EXTRACTION.—The evening before the time set for the removal of a cataract from a man sixty-two years of age, atropine was instilled into the eye. During the night this was followed by an attack of acute glaucoma, the tension of the eye equaling plus three. The writer operated at the time and removed the lens. The external condition abated and there seemed every prospect of recovery. The patient did not complain of any pain. Eserine, to counteract as far as possible the effect of the previously used atropine, was instilled. Four days later, when the eye was dressed for the first time, it was found that the anterior chamber was not refilled, the corneal wound being open. Otherwise the condition of the eye was good. All this time the patient had remained in bed. Eserine was again instilled and the eye was rebandaged. The patient was allowed to get out of bed for brief periods of time. On the sixth day the eye was again dressed. The wound was still ununited and the upper margin of the cornea was slightly hazed. Eserine was instilled for the third time and the dressing was reapplied. Two days later the eye was examined for the third time. The wound was healed and the anterior chamber was almost completely refilled. The corneal haziness had spread slightly, but as time went on it almost disappeared. The patient in the end made a good recovery.

Quereghui expresses the opinion that the retardation of cicatrization of the corneal wound was due to the outflow of the excessive amount of fluid in the eyeball that was dependent upon the glaucomatic process, and that when the effect of the atropine was overcome the wound was permitted to close. He takes occasion to call attention to his own theory of the nature of glaucoma (a theory of which, judging from his words, we may soon look for a fuller demonstration), which is that the disease is due to a passive or active hydropsy of the perichoroidal space, which extends from the insertion of the optic nerve to the point at which the choroid joins the iris.

The author considers that the beneficial action of iridectomy in glaucoma is due to the fact that the operation produces a communication between this lymph space and the posterior chamber. —*Annals d' Oculistique.*

William Spencer, M.D.

PILOCARPINE IN DEAFNESS.—The use of pilocarpine in certain forms of deafness is not altogether new, but Dr. Emery calls attention to the fact that it is more frequently overlooked than, considering the usually hopeless prognosis of nervous deafness, it ought to be.

He records two cases, in both of which total deafness came on suddenly with nausea and vomiting. In the first case, but not in the second, there was also vertigo, and right facial paralysis ensued. Subjective noises in the ears

were present in both cases. Both aërial and osseous conduction were obliterated. The first patient had a syphilitic history, but none could be elicited in the second. Severe pain was present in both cases—in the first at the back of the head and in the second at the vertex.

The author considers that in the first case the auditory centres in the cerebellum were probably the seat of syphilitic exudation, while in the second the lesion was probably labyrinthine and apoplectic in character, most probably due to the rupture of a small vessel in each of the two labyrinths simultaneously, the attack having taken place while the man was stooping at his work. The treatment consisted, after many other measures had failed, of injections of pilocarpine under the skin of the shoulder. The injections were at first of the strength of one-twelfth of a grain and were administered daily, but as the strength was gradually raised to one-third of a grain the frequency was diminished to every second and every third day. The patient remained in the recumbent posture for some six hours after each injection. Improvement in hearing manifested itself in each case almost immediately, and this progressed steadily. The author attributes the action of the drug to its stimulating the absorbents in the vicinity of the effusion before the latter had time to become organized. It is obvious, therefore, that the treatment requires to be begun as early as possible, and it is probable that it would prove useful in cerebral apoplexy generally.—*New York Medical Journal*.

William Spencer, M.D.

VAGINAL EXPLORATORY INCISION FOR EXTRA-UTERINE PREGNANCY. VINEBERG.—The writer recommends this for doubtful cases and if ectopic gestation is present to complete the operation by the suprapubic route. All cases of early abortion should be open to suspicion unless the conditions present were plainly evident. The flow attending a ruptured tubal pregnancy is apt to occur as a mere show, appearing and disappearing at intervals. The pain is often described like those of labor. No microscopical examination will determine the difference between the decidual cells of a uterine and of a tubal pregnancy. A mistaken diagnosis is apt to be made in cases of irregular sacculation of a pregnant uterus, elongation of the cervix and retroflexion of the uterus.—*Medical Record*, October 17, 1900.

George R. Southwick, M.D.

THERMAL CARBONATED BATHS IN GYNÆCOLOGY.—Bandler finds many chronic cases of various kinds in which the patients have a flabbiness and lack of elasticity which is a part of the general condition rather than due to the gynæcological condition, and which may be termed hysteroptosis. Thermal carbonated saline baths, on account of their effect on the circulation, are especially valuable in the treatment of such cases, and especially to promote the absorption of exudates and inflammations and for the relief of congestions.

The patient was first put to bed for a week to determine the value of rest. The baths were begun at a temperature of 27° R., lasting eight minutes, and contained half the strength of CO₂ contained in a Sprudel bath. The temperature of the water was lowered on succeeding days, no bath being given lower than 22° R., the amount of CO₂ being increased with the lower temperatures. Baths were given on three successive days, with a rest of one day before the next three baths. During menstruation no treatment was given, so that in four weeks the patients averaged eighteen baths each. All re-

mained in the clinic, and there was no change of diet. Improvement began in a few days, and was pronounced. There was a most rapid resorption of exudates and infiltrations, and a decided diminution in the size of the adnex tumors, the majority of which were pyosalpinx with severe symptoms. The cases called hysteroptosis were decidedly benefited. All the patients gained in weight and strength, and the number of red blood-cells was constantly increased. Appetite improved, and a feeling of strength and exhilaration resulted, such as no other treatment in my opinion could have accomplished in the same time.—*Medical Record*, November 24, 1900.

George R. Southwick, M.D.

THE RELATIONS BETWEEN THE INDICATIONS FOR CÆSARIAN SECTION, CRANIOTOMY AND PREMATURE LABOR.—I. Before the end of pregnancy.

If a pluripara, in consequence of a contracted pelvis, has had one or more very difficult labors, the induction of premature labor is indicated in the next pregnancy. The limit of this operation in the flat pelvis is 7 cm. of the true conjugate by $7\frac{1}{2}$ cm. in the generally contracted pelvis. The thirty-fifth week of pregnancy is the best time.

II. At the end of pregnancy.

Craniotomy is indicated if the child is dead and the progress of labor delayed.

Craniotomy is also indicated if the child's life is in danger, as shown by irregular heart sounds, discharge of meconium, twitching from suffocation, prolonged pulse in umbilical cord, prolapsed cord, etc., when in a contracted pelvis spontaneous labor does not occur, and when version and extraction are not allowable or forceps are too dangerous.

Cæsarian section or symphyseotomy may rescue such a dying child, but such a rescue is very questionable and improbable and at very great danger to the mother. The interests of the child in such cases should be subordinate to those of the mother and the family, and craniotomy should be performed.

If the vitality of the child is good, the mother perfectly healthy and in good condition, the course of labor normal and the patient in a hospital, craniotomy to-day would not be performed for a contracted pelvis. It is, however, indicated in private practice if, during spontaneous labor, the woman must be delivered in consequence of pelvic contraction and forceps and version are excluded, and also with careful criticism of the advantages of Cæsarian section or symphyseotomy and a consideration of all the circumstances of the case. The lowest limit of contraction for craniotomy is 6 cm. of the true conjugate.

It is also necessary to remember, both in hospital and private practice, the existence and future of a family may depend on the birth of a living child, though it may live but a few minutes, and due consideration must be given it in the council of physicians.

The indications for Cæsarian section may be relative or absolute; the former refers to a true conjugate of $7\frac{1}{2}$ cm., the latter to a conjugate of 6 cm. or less. Cæsarian section with relative indications requires that a spontaneous labor cannot be terminated with the aid of a colpeurynter and Walcher's position, that forceps and version are excluded, that delivery cannot be delayed, and that the patient must be in a hospital or private house under such conditions that the operation can be properly performed and the after-treatment

carried out. If these conditions cannot be obtained, craniotomy must be considered as a substitute operation. Cæsarian section must be performed if the true conjugate is 6 cm. or less.

Symphysiotomy is applicable to cases of pelvic contraction with a true conjugate of from $6\frac{1}{2}$ cm. to $7\frac{1}{2}$ cm. It competes with the relative Cæsarian section, and may at times be a substitute operation for craniotomy. The choice between symphysiotomy and relative Cæsarian section depends on the preference of the operator. The results for mother and child are about the same.—*Centralblatt für Gynäkologie*, No. 36, 1900.

George R. Southwick, M.D.

THREE VARIETIES OF MEMBRANOUS ANGINA PRODUCED BY MICRO-ORGANISMS OTHER THAN THE KLEBS-LÖFFLER BACILLUS AND THEIR SANITARY SIGNIFICANCE.—Bissell, Buffalo, N. Y., says that recent research has conclusively demonstrated that several varieties of pseudo-membranous inflammations of the tonsils classed as diphtheria have been produced by micro-organisms other than the Klebs-Löffler bacillus. The micro-organisms in question are the streptococcus pyogenes, micrococcus of sputum septicæmia, and the oidium albicans. These organisms, he states, can produce illness, having a clinical picture varying from the most mild sore throat to a fatal disease. The oidium albicans has never produced a membranous condition of the throat that, in the experience of the Bacteriological Department of the city of Buffalo, has resulted fatally. Instances of death from streptococcus and sputum septicæmic infections have frequently occurred.

He further states that these conditions cannot be classed with the contagious diseases, for though they are capable of transmission by direct inoculation, they do not appear to be communicable. From his experience with a number of cases, he draws the following conclusions:

1. The streptococcus pyogenes and micrococcus of sputum septicæmia can produce membranous anginas, accompanied by physical disturbances sufficient to cause death.
2. The oidium albicans produces pseudo-membranous exudates easily mistaken for Klebs-Löffler inflammations.
3. The only positive method of detecting a Klebs-Löffler infection is by microscopic methods.

From the sanitary standpoint as regards quarantine, anginas due to the streptococcus pyogenes, micrococcus of sputum septicæmia and the oidium albicans require little consideration.—*Buffalo Medical Journal*, December, 1900.

W. D. Carter, M.D.

THE LONGEVITY OF THE GONOCOCCUS.—Ruggles, Rochester, N. Y., reports a case wherein the gonococcus persisted for more than ten years, in the absence of all suspicious coitus. The patient contracted gonorrhœa in 1887, and until 1900 had been free from discharge, although crop shreds had always been present in the urine. Married in 1891, had not practiced intercourse for over a year before marriage, and had no extra-marital relations since. In August, 1900, after drinking several cocktails and three or four glasses of beer, practiced coitus, which was extremely protracted. On August 22d was examined for discharge, and numerous gonococci were found.

The wife had, apparently, never been infected. Most authorities give the life of the gonococcus from four to five years.—*Buffalo Medical Journal*, December, 1900.

W. D. Carter, M.D.

THE TREATMENT OF CHRONIC CYSTITIS IN THE FEMALE BY CURETTEMENT OF THE BLADDER AND INSTILLATIONS OF CORROSIVE SUBLIMATE.—Cumston, Boston, Mass., after describing the anatomy, physiology and pathological conditions incident to chronic cystitis, describes the technique of curettement as follows:

The bladder being empty, two fingers are introduced into the vagina and the anterior wall is pushed upward and forward. The curette is gently drawn over the posterior surface of the bladder, the fingers in the vagina offering the resistance, the pubes answering the same purpose for the anterior wall. The apex and lateral walls are less easily reached, but, as he points out, the lesions are less numerous there than in other portions of the bladder.

The instruments necessary for intra-vesical instillations are a syringe with a capacity of four cubic centimeters, preferably one made with a glass reservoir and rubber mountings, so that the salt will not attack it, and a small, perforated, bulbous catheter, not larger than a 12 or 14 French scale. The patient is directed to empty the bladder immediately before the operation. The syringe is then filled with the solution, its point is introduced into the end of the sound, and a little of the solution pushed through it so as to drive out the air. The sound is then gently introduced into the bladder and a quantity of liquid slowly injected. After the sound has been withdrawn, it is well to tell the patient to turn first on one side, then on the other, and then on the abdomen, so that the solution will come in contact with all parts of the mucous surface of the organ.

The instillations are given every day, gradually increasing the strength of the solution from 1-4000 to the point of tolerance of the mucous membrane. From his own experience and that of others who have treated cases by this method he bases the following conclusions: (1) Sublimate instillations will often produce a very great improvement in the distressing symptoms met with in both tuberculous and non-tuberculous cystitis. (2) When the instillations fail to produce the desired effect, curettement of the bladder is indicated in both tuberculous and non-tuberculous cystitis. (3) In gonorrhœal cystitis instillations of sublimate are particularly efficacious and rapidly subdue the pain. (4) Under favorable circumstances a radical cure of primary tuberculosis cystitis may be obtained by curettement when the vesical lesions are localized and the kidneys free from the disease. Curettement per urethram will not allow the surgeon to reach the entire surface of the bladder, so that when the lesions are extensive they should be directly treated by suprapubic cystotomy. (5) Much relief may be afforded by curettement to a large number of patients suffering from tuberculosis of the bladder, but who, on account of the advanced stage of generalized infection, are in no condition to undergo a more radical operation. (6) When cystitis is due to a prolapsus of the genital organs, and when hysteropexy, combined with anterior and posterior colporrhaphy, does not relieve the bladder symptoms, curettement of the bladder, followed by sublimate instillations, is the proper treatment.—*New York Medical Journal*.

W. D. Carter, M.D.

STOMACH CONDITIONS IN EARLY TUBERCULOSIS.—Boardman Reed, reviewing the gastric conditions present in the early stages of pulmonary tuberculosis, emphasizes the following conclusions:

1. In early tuberculosis the secretion of HCl in the stomach is very fre-

quently excessive, the peptic glands being in a condition of irritability, which causes stimulant remedies of the creosote class to disagree and act injuriously.

2. Oils tend to depress the secretory function of the stomach, and in consequence cod-liver oil is likely to help the cases which the creosote class of drugs hurt; but, on the other hand, hurts the cases in which the gastric secretion is inactive, the very ones in which creosote and the like often do good.

3. Therefore it ought to be the rule to ascertain the condition of the secretory function of the stomach before pushing either class of remedies.

4. When analysis of the gastric contents cannot be made, it is safer to combine creosote with cod liver oil, so as to let one neutralize the other in their influence upon the stomach.

5. The motor function is very generally depressed in tuberculosis and must be restored before a cure can be brought about. Drugs avail little in this direction, but diet, exercise, especially in the open air, faradism and abdominal massage—except when hyperchlorhydria complicates—are all valuable means of effecting the result.—*Phila. Med. Journal*, Dec. 1, 1900.

F. Mortimer Lawrence, M.D.

SUPRARENAL GLAND IN HAY FEVER.—Somers, of Philadelphia, was induced by the claims of Solis-Cohen and others to administer suprarenal extract internally in twenty-one cases of hay fever. Only unfavorable conclusions can be drawn from his report. The nasal symptoms, as sneezing, rhinorrhœa and obstruction to breathing, were but slightly influenced. The sneezing attacks were apparently more infrequent while the drug was being used, but the attack in itself was as severe as before. The nasal obstruction was somewhat favorably influenced in about one-half of the cases. The rhinorrhœa was uninfluenced in any way. Six of the patients in whom asthmatic symptoms pre-existed were unfavorably influenced, the paroxysms becoming more frequent and of greater intensity. In five cases in which asthma had not previously existed it occurred during the administration of the drug, and also disappeared, not to return, when the latter was withdrawn. Other disagreeable effects were nausea and a sense of chest-constriction. These facts, however, in no degree reflect upon the value of the remedy when used locally.—*Phila. Med. Journal*, Dec. 8, 1900.

F. Mortimer Lawrence, M.D.

ANTISTREPTOCOCCIC SERUM IN THE FEVER OF TUBERCULOSIS.—Shively, of New York, states that in cases of mixed infection, when streptococci swarm in the sputum, when there are severe chills and wide excursions of temperature, with profuse sweating and septic symptoms, he has seen improvement follow the injection of Marmorek's antistreptococcus serum, as prepared at the Pasteur Institute of Paris. In one case, after the administration of three injections of 20 ccm. each, there was a complete disappearance of the streptococci from the sputum, the chills and sweats ceased, the temperature diminished, and there followed a marked improvement in the appetite and general condition of the patient. In other cases no improvement was seen, or the results were slight or of brief duration.—*Phila. Med. Journal*, Dec. 1, 1900.

F. Mortimer Lawrence, M.D.

THE DETECTION OF INCIPIENT PULMONARY TUBERCULOSIS.—Shively, after reviewing the physical signs of tubercular invasion of the lung, states that the detection of the tubercle-bacillus in the sputum is, of course, of the greatest

importance; but, unfortunately, in the earliest stages bacilli are frequently not present, and the microscopic examination will often be corroborative rather than primary. The tuberculin test, which is so valuable in veterinary science in establishing the diagnosis of bovine tuberculosis, should not ordinarily be employed in man on account of the occasional severity of the reaction and the possible danger of lighting up quiescent foci of infection. Its use will be necessary but rarely. Should it be employed at all, it should be remembered that the reaction occurs also when syphilis is present. A limited experience with the application of the Röntgen ray and fluorescent screen to the examination of chest cases would indicate that, although often affording a beautiful demonstration of the extent of tuberculous lesions in advanced cases, it is doubtful whether they can give any material aid in the early diagnosis of incipient disease.—*Phila. Med. Journal*, Dec. 1, 1909.

F. Mortimer Lawrence, M.D.

A SIMPLIFIED METHOD FOR EXAMINING STOMACH-CONTENTS.—Bastedo, of New York, recommends an unbuttered roll and twelve ounces of water as a test-meal, to be withdrawn one hour later in the usual fashion. The liquid evacuated contains a sediment of more or less digested bread. If fermentation is going on in the stomach, there is a layer of foam on the surface and an odor of butyric acid. Five cc. of the filtered contents are placed in a porcelain dish with a drop or two of one-half of one per cent. alcoholic solution of dimethyl-amido-azo-benzol. If this becomes pink, it indicates the presence of free hydrochloric acid, and this is estimated by adding a decinormal sodium hydrate solution from a Mohr's burette, until the yellow color is restored; the number of cc. of soda solution used indicates the amount of hydrochloric acid present. To the same 5 cc. are added a few drops of one per cent. solution of Congo red, and this, if any further free acid is present, turns violet. Such free acid is organic, and is estimated by adding the sodium solution until the red color returns. Lastly, a few drops of one per cent. alcoholic solution of phenol-phthalein are added and the sodium hydroxide continued until the resulting pink color becomes no deeper on the addition of a single drop of the decinormal solution. This represents the combined acid or acid albumin and the acid salts.

As 5 cc. of stomach contents have been employed, the number of cc. of sodium hydroxide used in each case must be multiplied by 20 to represent the ingredients in 100 cc. Normally the return from the test-meal should be 60 to 100 cc. with acidity 50 to 60, free hydrochloric acid 10 to 15, combined acid 40 to 50, no organic acid, and only slight mucus.

The lactic-acid forming bacilli do not grow in the presence of free hydrochloric acid, so if this is found lactic acid is not tested for; but if hydrochloric acid is absent, and the Congo red reaction is positive, the lactic-acid test may be made with tincture of iron.—*Med. News*, Nov. 10, 1900.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF INTERNAL HÆMORRHAGES.—In a discussion before the British Medical Association, Smith, of Dublin, asserted that the sources of hæmorrhage are three, namely: (a) capillary—oozing or rupture, for example in early phthisis; (b) venous—oozing or rupture, for example hæmatemesis in hepatic cirrhosis; varicose veins; (c) arterial rupture, for example aneurysm and phthisis in its later stages. It is idle to speak of a common treatment for all of these.

The processes by which hæmorrhage can be arrested are closure of the bleeding point mechanically by ligature, simple pressure, acupressure, torsion and the like; or coagulation of the blood at the source of bleeding produced by (a) certain changes in and around the bleeding vessels, namely, retraction, constriction of the blood-vessels, and clotting within and without the vessel; (b) diminution of the force of the heart's action—that is, a considerable fall in blood pressure; in some cases of “bleeders” the only cure for hæmorrhage seems to be to faint—that is, to bring the blood pressure to a very low ebb; (c) alterations in the chemical constitution of the blood whereby clotting is favored, and coagulation tends to occur at a damaged portion of tissue; this is the principle of Wright's proposal for the administration of calcium chloride.

Leaving out of consideration approved surgical means for stopping hæmorrhage, the treatment consists of local styptics, of whose efficacy there can be no doubt and which act mainly in virtue of their albumin-coagulating properties; and of internal hæmostatics, whose number affords additional proof that in a multitude of remedies there is no cure. Most of these latter can be grouped under three heads, namely: (a) free acids, chiefly sulphuric and tannic; (b) metallic salts, chiefly of iron, silver, lead and copper; (c) ergot of rye.

Of the vegetable astringents there is absolutely no foundation for the reputation of gallic acid; it is not even a local styptic. Tannic acid has a local action, but used internally it is absorbed and excreted in the urine as inert alkali tannate. The use of ergot is traditional; its users offer but faint praise; and we cannot even confidently say that it does no harm—the widespread narrowing of peripheral blood-vessels tends to raise blood pressure, and this would be the worst possible thing to do in a case of hæmoptysis. What is rational, then, in an urgent case, say of hæmoptysis?

(1) Reassure the patient and his friends by a few simple directions, and emphasize the fact that hæmorrhage *per se* is rarely a matter of urgency.

(2) Avoid irritation of the gastric ends of the vagus nerve. Do not administer cold drinks or pieces of ice. Allow, on the contrary, warm mucilaginous drinks.

(3) Keep the patient absolutely quiet in body and mind.

(4) Give morphine hypodermically; this is the best thing of all to do.

(5) Relieve the bowels freely by magnesium-sulphate or by calomel.

(6) Let the diet be simple and nutritious, reduce the amount of fluid, and give no alcohol.

In the ensuing discussion, Dixon, of Cambridge, discussed the value of urethane in hæmorrhage of the bowel, and advocated the use of suprarenal extract in hæmorrhage from the stomach. Kingscote, of London, recommended endeavors to attract the blood elsewhere by heat applied to the extremities, etc. Wynter referred to the method of increasing the coagulability of the blood by the subcutaneous injection of gelatine solution, and cited the original cases of Drs. Lancereaux and Pautesco, who thus cured three sacculated aneurysms.—*British Medical Journal*, Oct. 13, 1900.

F. Mortimer Lawrence, M.D.

THE DIAGNOSIS OF SUB-DIAPHRAGMATIC ABSCESS.—In opening a discussion of subphrenic abscess before the British Medical Association, Godlee, of London, stated that such an abscess is not an isolated disease, but the by-

product of some other phenomenon, and probably the symptoms of the disease that causes it will be the prominent ones. No symptoms are pathognomonic. In the early stages it may cause hiccough and a sharp stitch, like that of pleurisy, and friction. This friction may be heard, or friction fremitus may be felt. Later on it may give rise to dullness at the lower part of the chest on either side. This may be accompanied by displacement of the heart. It may be distinguished from the dullness of a pleural effusion by the following signs :

1. The movements of the chest are not impaired on the affected side.
2. The upper limit of dullness is not so sharply defined.
3. Breath sounds may be heard below the level of the dullness, and, if a deep inspiration be made, the line at which the breath sounds and vocal resonance are heard, and at which vocal fremitus is felt, is distinctly lowered.
4. If you examine a very emaciated person on the right side in a good light you will see, if the pleura be healthy, the lower margin of the lung moving up and down during respiration.
5. Instead of dullness, there may be a great extent of tympanitic resonance, and over the resonant area the bell sound may be elicited in a most perfect manner. This only occurs in cases where gas as well as pus is present, and from the similarity of the sound to those of pneumothorax has given rise to the name "subdiaphragmatic pneumothorax." This condition is to be diagnosed in most cases from genuine pneumothorax by the fact that the movements of the thorax are not impaired.

In the course of the ensuing discussion, Fuller, of Cape Town, stated that he had seen several cases in which the collections of pus had been shown to have a connection with gastric or duodenal ulcers by the discovery in the pus of the bacterium coli. In all cases when pus was discovered by the needle, or otherwise, a microscopic and bacteriologic examination should be made, and it is often a valuable aid to diagnosis.—*British Medical Journal*, Oct. 6, 1900.

F. Mortimer Lawrence, M.D.

TREATMENT OF ALOPECIA.—Schaeffer proposes a method based upon the antiseptic properties of bichloride and the sudorific qualities of pilocarpine. The alopecial patch is cleaned with 90 per cent. alcohol, and a syringe is filled with the two medicaments. It holds about 12 minims. The upper third is filled with HgCl_2 solution 1 : 1000, the second with 1 : 200 pilocarpine nitrate, and the lower third with 1 : 1000 HgCl_2 . The needle is introduced parallel with the scalp, and just underneath the epidermis; it is then emptied, and leaves a small swelling. Such is repeated around the periphery of the patch, and in a circle within it, the punctures being about 1 cm. apart—an alopecial patch, the size of a silver dollar, requiring about 12 punctures. The seance should be repeated every other day for some six or seven times. The immediate effects produced are an anæmic zone, followed by a marked vascularity, lasting for several hours. Five or ten minutes after the injection, drops of sweat appear on the vascular zone, and this continues for an hour. The secondary results are immediate arrest of the alopecial extension, and a gradual regrowth of hair from periphery to centre. This growth should be evident after four seances, but in all cases the treatment should be persistent. Its extent should be based upon the size of the bare patch, the age of the lesion, the position—temporal and occipital alopecia is always the more difficult to obtain good results—and the age of the subject.—*British Medical Journal*, Dec. 8, 1900.

MONTHLY RETROSPECT

OF HOMOEOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

"TREATMENT OF GLAUCOMA," BY DR. PARENTEAU, OF PARIS.—*Atropinum sulfur*.—Third to twelfth, increased tension with hyperæmia of the conjunctiva and production of follicles, mydriasis.

Cocaine.—Sixth to thirtieth, increased tension with considerable pupillary dilatation and decreased corneal sensibility.

Glonoïn.—Increased tension with venous dilatation and pulsation and arterial shrinking.

Belladonna.—Hypertension with eyes injected, mydriasis, photophobia, lachrymation, agonizing pains, vertigo.

Aurum.—Hypertension with a painful heavy sensation, myosis more frequent than mydriasis. Especially indicated in those glaucomatous states occurring after total synechiæ; also valuable in those who have a syphilitic history.

Causticum.—Hypertension with dull and continuous pain. Accommodative asthenopia, paralysis of ciliary muscles and dimness of vision.

Chelidonium majus.—Same indications as for causticum, plus pains extend to the sub-orbital nerves and ecstasy of the anterior membranes.

Magnesia carb.—Hypertension, following traumatic cataract or ocular lesions. The pains are pulsating, tearing in character, and are paroxysmal.

Nux vomica.—Hypertension with congestion of the sclero-choroid, pupils slightly dilated, burning sensation and darting pain in the eye, morning aggravation.

Phosphorus.—Hypertension with intense passive congestion of the deep membranes. The visual field is greatly shortened, the pupil is slightly or not dilated, but there is always a perikeratic circle present.

Spigelia.—Hypertension with stabbing pains occurring in ulcerative keratitis of strumous origin, or following the entrance of foreign bodies. It is also valuable in rheumatic iritis.

Remedies Indicated in Cases of Decreased Tension—*Esérine*. Twelfth to third decreased tension with myosis, and sclero-corneal irritation.

Natrum mur.—Used in high dilutions, decreased tension with opacity of the lens and objective myodesopsia.

Apium virus.—Decreased tension with congenital hyperæmia, deep corneal ulceration and perforation, marked photophobia, and myosis is always very marked.

Ranunculus bulbosus.—Decreased tension occurring after iritis or irido-choroiditis.

Dr. Parenteau insists upon paracentesis or sclerotomy instead of the so much abused method of iridectomy.—*L'Art Medical*, September, 1900.

John Arshagouni, M.D.

APIS MELLIFICA.—Dr. A. Leight Monroe, in a paper read before the Kentucky Association, considers this remedy the most important one we have for the treatment of dropsies inside serous sacs. He mentions, by way of example, hydrocephalus, pleuritic, pericardial and peritoneal dropsies, ovarian dropsy, and the synovial effusion of acute articular rheumatism. In this latter condition, he refers to the symptoms "stinging pain, with pale pink color of inflamed joints," as important. He reports a case of ovarian tumor in which apis 30th has "reduced the patient's waist measure six inches in about four months."—*American Homoeopathist*, December 15, 1900.

O. S. Haines, M.D.

CRETÆGUS IN TYPICAL CARDIAC CASES.—Halbert, of Chicago, reports favorably concerning this remedy. In the *Medical Era* for December he narrates the histories of three cases in which the remedy was used.

Case I.—A driver for grocery firm, aged 30 years. Aortic regurgitation. A history of alcoholism and perhaps syphilis. This patient had received much relief from argentinum nitricum, and for a time considered himself quite well. Suddenly he was attacked with anginal symptoms, dyspnœa, palpitation and extreme pain, followed by decided dilatation of the heart. The regurgitant sounds became more pronounced, and the apex-beat was displaced. Compensatory hypertrophy failed decidedly. *Cretægus tincture* was given in five-drop doses every three hours. The remedy was given regularly for several months, then intermittently. The dilatation was overcome, a safe compensatory hypertrophy exists, the rhythm is nearer perfect, the heart-sounds normal, he is able to endure considerable strain and his systemic symptoms have been relieved.

Case II.—Aortic regurgitation in a young man aged twenty years. After excess in bicycle riding, had an attack of dilatation and nearly lost life. Digitalis helped him, though compensation was far from perfect. Apocynum afterwards helped him, but later made him worse, as it was used until its physiological effects were produced. When Dr. Halbert was called his condition was extreme, the præcordium was bulging, apex down to lower border of sixth rib, epigastric pulsation marked, violent heaving of entire chest on left side, aortic and mitral regurgitation extreme, terrible dyspnœa, marked cyanosis. Thought patient would not live twenty-four hours. Digitalis and strychnia failing, patient received *cretægus tincture* in five-drop doses four times daily, later increased to ten-drop doses. Within a few days heart became quieter. In two weeks improvement was marked. Unfortunately, about this time, patient contracted a pneumonia, which required special treatment. After his recovery from the pneumonia the *cretægus* was resumed. His heart is now giving him no trouble, he attends to business, and claims to feel "well."

Case III.—Mitral regurgitation in woman aged 45 years. The writer had treated this case for years with but little success. Other physicians had also prescribed the usual heart remedies. After two years' wandering the patient returned to Dr. Halbert. The heart was found to be greatly enlarged, with incomplete compensation. Her symptoms were extremely severe and characteristic. She was put to bed and received *cretægus tincture*. Gradually she improved, and was sent to a warmer climate for the winter. After returning, she felt that she was so well that she over-exerted herself, and finally suffered a relapse, induced by a fright. After a long illness she died.

The principal indication for the *eretægus*, so far established, seems to be those symptoms defining the failure of compensation. In physiological doses it will produce these symptoms accurately upon the healthy. The best results have been obtained from the tincture administered for some time. Many physicians have reported failures, but a few have had excellent success with it.

O. S. Haines, M.D.

THE THERAPY OF ANÆMIA.—Royal, of Des Moines, gives in a short paper recently published the indications for the following remedies, which in his experience have been found useful in the treatment of anæmia:

China.—The foremost remedy for the symptomatic variety. When given for the anæmia immediately following a profuse hæmorrhage, five-drop doses of the tincture in water. When, however, much time has elapsed since the drain was made upon the system, when the patient complains of ringing in the ears, with a pale, sallow complexion, with pulsating headache, with bloated abdomen, with anorexia, painless diarrhœa, worse at night, stools of undigested food and cadaverous odor, with tendency to dropsy, with profuse perspiration and a history of some previous drain upon the system, he tells us that the 30th potency gives better results than the low preparations, and that it is a mistake to give the latter.

Ferrum.—*Ferrum phos.* in the low preparations, when you have the ferrum headache, the pallor and peculiar flushing of the face, the cold hands and feet, the pale mucous membranes, in persons of hæmorrhagic diathesis and of *phosphorus* build, or where there is a tendency to tuberculosis. On the other hand, he prefers the *ferrum metallicum* where the patient is rather of the *calcareæ* build than the tall, slim *phosphorus*, with undigested diarrhœa, flushing of the face, and yet pallor of skin and mucous membranes. He prescribes the 30th here.

Calcareæ Carb.—He has given this remedy successfully when the following indications were present: Constant worry about what is in store for them; anticipates dire calamities; sour, unfermented, undigested diarrhœic stools, coming on soon after eating or drinking; distention of the stomach and abdomen; palpitation of the heart and great weakness after exertion. Other reliable indications are the excessive sweating about the head, the disgust for meat, the craving for unnatural things, cold hands and feet. In the female, the menses are too frequent and too profuse, and the bland white leucorrhœal discharge is also profuse.

Phosphorus.—Hæmorrhagic and tuberculous diatheses. Tendency to fatty degeneration of heart or liver. The phosphorus patient is always exhausted. Brain is tired and body easily exhausted from least exertion. Palpitation of heart and inability to lie upon left side. Tenderness of liver and spleen. Stools diarrhœic, painless, fœtid, undigested or covered with small white particles.

Pulsatilla.—The peculiar mental symptoms of this remedy afford us good indication. Also vertigo, amenorrhœa, or scanty, late menses. Irregular pulse and constant chilliness. Sallow face, frequently flushed. The remedy is especially adapted to cases of chlorosis.

Picric Acid.—The writer believes this remedy has been sadly neglected. It causes disintegration of blood-corpuscles. Produces violent occipital headache, with heavy sensation, as if occiput was filled with lead. Mental exer-

tion aggravates. Vertigo and deafness may be present. Prostration marked and profound. Diarrhœa of light-colored or yellow stools. The history shows excesses in venery or brain work. He gives picric acid where formerly phosphoric acid was used, and has been gratified with results.

Chininum Arsenicosum.—With this remedy he cured a case that was in desperate straits. The spleen was much enlarged and tender. Brown, offensive diarrhœa and cold sweats. Prostration extreme. Extreme restlessness. The proportion of red and white corpuscles was as ten to one. The patient had malaria, and had taken enormous doses of quinine: *Natrum mur.* and *arsenicum* failed, but *chininum arsenicosum* 6x cured.

Arsenicum Album.—Rapid emaciation, the tissues seem to melt away, increasing prostration, irritability of alimentary canal, stomach refuses to retain either food or drink, intense thirst, dark excoriating stools, skin dry and unhealthy, tongue thinly coated white, with red streak down the centre. *Arsenicum* 30th has checked the downward course in a number of such cases. As a rule, however, while arsenic brings about a reaction much as does sulphur, another remedy will be required after it to complete the cure of the case.—*Hahnemannian Advocate*, Oct. 15, 1900.

O. S. Haines, M.D.

THE THERAPEUTICS OF CHOREA.—Dr. Giles F. Goldsbrough, in a noteworthy paper presented to the British Homœopathic Society, calls attention to the large number of cases of chorea, amounting almost to an epidemic, that were treated in the London Hospital during the earlier months of 1900. He conjectures that the exciting news of military adventure had something to do with this. He groups the *causes* of chorea, apart from age and sex, as follows:

Emotional.—Fright, anxiety, intellectual tension, over-study.

Toxæmic.—Rheumatism, scarlet fever, measles or other exanthem, and possibly menstrual suppression.

Reflex.—Worms, phimosis, dental caries, disorders of menstruation, pelvic anomalies and pregnancy.

The history of Case I. in this paper is interesting. A woman aged 25 years was suffering from emotional form, caused probably by domestic infelicity, and, resisting the influence of internal remedies for some weeks, was suddenly cured in the following unique manner. She was asleep in the hospital ward, when suddenly and without warning the huge ventilator fell with a loud crash. The patient awakened, had immediately strong flexion of all her extremities, then relaxed, and from that moment was quite free from choreic movements. The author suggests that such an accidental recovery indicates not in degree, but rather in kind, the treatment applicable to cases of the emotional class, namely, the induction of another kind of emotion upon that originally the cause of the disease. He specifies, in this connection, isolation of the patient, the influence of a judicious nurse, who must be a stranger to the patient, the fostering of the element of mental interest, the training of the will, new occupation, and change of scene. In this class of choreic patients the choice of internal remedies will usually rest between *agaricus* and *ignatia*. The distinguishing indications for these remedies may be stated thus:

Ignatia.—Mental chorea. The mind is in a hurry, cannot accomplish what it wishes. Emotional state is one of fear, with alternations of gaiety and quiet

sadness. Sensitiveness to external impressions, especially of higher nervous centres.

Agaricus.—Mental exhilaration with subsequent vacancy of mind. Weakness precedes movements. Pains of various kinds in joints and limbs precede and follow movements.

Hyoscyamus or *Stramonium* are recommended for this class of patients who do not sleep well or sufficiently. *Arsenicum* is spoken of as the most frequently indicated remedy for the ordinary toxæmic cases, but if uterine irritability complicates such cases then *actea racemosa* will be of more benefit. Tangible doses of the actea must be given, but never push the dose of arsenic so far as to be dangerous to the integrity of nerve tissues. The latter remedy yields its best results in either the 3d or 6th cent. dil.—*Journal of British Homœopathic Society*, October, 1900.

O. S. Haines, M.D.

THE REMOVAL OF THE TONSILS.—Hooker, of Hartford, Conn., in a recent paper upon this subject, argues for the operative treatment of permanently enlarged tonsils. He has abandoned other methods in favor of the snare, and claims that, with a proper instrument, there is no hypertrophy so tough that the wire will not cut through it, nor is there danger of the snare doing harm by dragging on adjacent structures. In his experience this method is rarely followed by hæmorrhage in the adult, and never in children.

The discussion that followed the reading of this paper was a very full one. Dr. A. W. Palmer said that he regarded the removal of the tonsil as merely the commencement of the treatment. He always required before operating the promise of the patient that he or she would remain under treatment for a period of six or eight months. Such patients, especially children, need a plainer, more nutritive diet, fresh air, sunlight, cod-liver oil, and especially the indicated homœopathic remedy.

Dr. G. B. Rice spoke of the necessity of treating the patient, not necessarily the hypertrophy of the tonsils, but treating the patient individually. We have no better means of controlling the development of hypertrophy, if the tendency exists, than the indicated homœopathic remedy.

Dr. R. S. Copeland referred to the widespread skepticism concerning the value of the internal remedy in the treatment of enlarged tonsils. He called attention to the remarks "of one of the best general practitioners in the country," made at the American Institute meeting, who said that previous to his prescribing *tuberculinum* and *bacillinum* he always met cases of enlarged tonsils with grief and perplexity. Since using these remedies, however, he receives these cases with pleasure. The indications given for these remedies were as follows: *Tuberculinum* was indicated for dark, swarthy individuals and *bacillinum* for fair complexioned people. The 200 potency had been used. It would seem desirable that such a startling therapeutic recommendation as this should be quickly proven to be either true or false.—*The Hom. Eye, Ear and Throat Journal*, December, 1900.

O. S. Haines, M.D.

NOTES ON MORNING DIARRHŒA.—Duncan, of Chicago, under this heading, groups the more prominent remedies and their special indications as follows:

Sulphur.—Painless, imperative diarrhœa, driving patient out of bed early, from four to six o'clock.

Podophyllum.—Yellowish, profuse, painless, bilious stool, with meal-like sediment, worse anywhere from 6 to 10 A.M. The liver may be enlarged.

Natrum sulphuricum.—Diarrhœa comes on as soon as the patient stands upon his feet in the morning.

Bryonia alba.—Diarrhœa worse from motion in the morning, or at any time. Bilious stools followed by, or alternating with, the bryonia constipation, in which latter condition the stool may be dry, burnt balls.

Aloes soc.—Full rectum and an unreliable sphincter. Flatulence. The patient is driven out of bed early.

Rumex crispus.—Colicky pains in abdomen and early morning diarrhœa. Tickling in the throat, which, like the diarrhœa, is nervous.

Kali bich.—Gushing, watery diarrhœa at 2 A.M. Wakes with the urging. The stool may become mucous, but rarely bloody like mere. The tenesmus in both is similar. In the dysentery of infants prefer kali.

In his *Observations in Acute Articular Rheumatism* Dr. Wapler, of Leipzig, extolls the action of benzoic acid as superior to the formal treatment with the preparations of salicylic acid in shortening the course of the disease and in preventing heart complications. He does not use it in the large doses recommended by Senator, but of the second dec. trituration, about 0.2 to 0.25, every two hours, and in severe cases every fifteen minutes for one or two hours during the afternoon.

For the temporary, but often necessary, relief of the pain he applies cold or hot water applications and bandages, according to the feelings of the patient, alone or medicated with diluted bryonia tincture; also compresses with a glycerine solution of ichthyol or salicylate of methyl. During convalescence steam baths and massage are of use.—*Allgemeine Hom. Zeitung*, Dec. 6, 1900.

RENAL COLIC CURED BY SARSAPARILLA 6.—A woman, 33 years old, had suffered for three years from severe pains in the region of the kidneys, extending down to the os pubis. These were at times so severe as to demand the use of narcotics. During the attacks but little urine was passed, and it was cloudy, containing gravel and small calculi, some of which were as large as grains of wheat. Pains reached their climax at the close of micturition. A chill, beginning at the mouth of the urethra and extending thence over the whole body, usually accompanied the pains. There was also occasional constipation with violent strangury. The patient was thin, with wrinkled face and dark complexion, looking older than she really was.

On the use of sarsaparilla 6 the attacks became less frequent, the urine contained less gravel, and the movements of the bowels more regular. The patient gained in weight, and at the end of three months was entirely restored to health.—*Hom. Monatsblätter*, December, 1900.

CHRONIC RHEUMATISM CURED BY KALMIA LATIFOLIA 3.—This remedy was given to a young man 26 years of age, whose father was rheumatic, with the result of bringing about a cure in four weeks. It was given because the pains changed their location under the use of warm applications, because they passed from above downwards, and because the pains in the region of the heart radiated into the left arm, causing there a crawling sensation with numbness. Besides these symptoms, the patient complained also of pulsating, beating pains in the head, with pains in the eyes when moving them. Although the appetite was good, each meal was followed by an accumulation of gas in the stomach, with distention and dyspnœa.—*Hom. Monatsblätter*, December, 1900.

THE HAHNEMANNIAN MONTHLY.

FEBRUARY, 1901.

APPENDICITIS: CHOICE OF METHOD OF TREATMENT.

BY GEORGE W. ROBERTS, M.D., NEW YORK.

(Read before the Interstate Medical Society, Scranton, Pa., November 15, 1900.)

THE cure of disease is the great goal toward which we should all bend our energies. Hahnemann, in his scholarly definition of the physician's duty, embodies this thought in most accurate and concise terms when he says: "The first and sole duty of the physician is to restore health to the sick. The perfection of a cure consists in restoring health in a prompt, mild and permanent manner; in removing and annihilating disease by the shortest, safest and most certain means, upon principles that are at once plain and intelligible."

At varying intervals in the progress of our experience and knowledge of disease we, as interested physicians and surgeons, collect and tabulate the reported cases of the disease under consideration and from various sources draw what conclusions we can. As change of method is introduced, and as given methods are more perfectly applied, change of conclusions results. This applies particularly to the choice of methods of treatment, and in this case it often happens that the logical conclusions of yesterday are by no means valid to-day.

At this time the above remarks apply with unusual force to our conclusions as to the relative merit of medical and surgical methods in the treatment of a wide range of diseases. Surgi-

cal procedure, particularly surgical technique, has advanced with such rapid strides that the conclusions which seemed valid but a short time ago are now obsolete, and it is necessary for us to re-survey the field with great frequency, and always without prejudice, in order to keep ourselves abreast of the times.

Choice of a method of treatment in a given class of cases must be guided by two lines of thought. We do not essay to decide which of these lines is the more important—in fact, we believe they go hand in hand, and that, if our reasoning is logical, they will give identical results. These two guides are: (*a*) Pathology of the disease, and our theoretical ability to modify that pathology, and (*b*) Clinical evidence.

In using the term “clinical evidence,” we wish to define strictly what is meant. The term *does not* apply to that indefinite impression which comes to one after the treatment of many cases, which, occurring in the midst of an active practice, are unrecorded, unclassified, and not closely observed. Such impressions are exceedingly misleading, as any one can testify who keeps records of his cases, and, after having drawn a conclusion from memory relative to a certain class of cases, takes the pains to analyze and classify his records.

The clinical evidence which is valuable is that which comes from the careful, honest record of cases, and this evidence is valuable just in proportion to the intelligence and integrity of the witness.

In speaking of the selection of a method of treatment for appendicitis, it is not necessary at this time to go exhaustively into the pathology of the disease. We take the liberty, however, of speaking of some of the salient points. It seems useless for us to try to classify the cases, as so many authors have done, because there is no practical basis for a classification. No classification can be made with a degree of certainty before the termination of the case. The different kinds of appendicitis are merely modifications of the same process, as dictated by circumstances which cannot often be determined before the abdomen is opened, or the case has terminated in partial or complete recovery, or death. This we know with certainty in a given case of appendicitis, that we have in the tightly-closed abdominal cavity, in addition to its vital organs, an inflamed, useless remnant of the alimentary tract, which, even when

healthy, is particularly dangerous for the following, among many reasons:

1. All the rest of the normal alimentary tract forms a continuous canal. Considering any one section by itself, it has an opening of entrance and one of exit, so that, in case of any deleterious matter gaining an entrance—be that material chemical or bacterial—its exit is practically as easy as its entrance, and is even assisted by the ordinary fecal circulation. The vermiform appendix, on the other hand, presents but a single opening, and any irritant finding an entrance must return by the same route, unassisted by fecal or other currents.

2. It is the narrowest portion of the alimentary tract, and therefore friction is likely to be great, in case of a rough particle gaining entrance.

3. It is located at the bottom of the only portion of the tract where gravitation exercises a material retarding influence on the progress of the fecal mass.

4. Its own direction is, except in some cases where its mobility is seriously interfered with, unfavorable for the onward progress of any material which may have become entrapped in its lumen.

5. Frequently the appendix has anatomical surroundings which seriously hamper its mobility—*i.e.*, it is often located in a pocket, or is encircled by a fold of peritoneum.

6. It consists of a tube made up of three essential coats, the external of which (the peritoneum) is so inelastic that when the internal coats—which are vastly out of proportion to the size of the tube in their thickness, almost completely filling it even when uninflamed—become inflamed, they produce such a pressure within the tube that they choke off their own blood-supply, to an extent varying from the production of a lowered resistance to actual sudden gangrene of the appendix.

7. The blood-supply of the appendix—in the male especially, and often in the female—is exceedingly poor, being derived from a single arterial twig which courses within the inelastic external coat, and is, therefore, easily compressed, even if it does not become thrombosed.

8. The internal coat is soft and succulent and easily takes on the inflammatory process, since the necessary germs are always at hand.

9. The organ is so deeply located that, while we are able to palpate it under favorable circumstances, we cannot at the most critical moments estimate with anything like certainty its condition.

Now, having this state of affairs to deal with—and no one can gainsay the accuracy of these statements—what methods can we look to as routes toward the patient's recovery? They are, in general, (1) expectancy, (2) medical means, (3) surgical means.

1. Expectancy, or non-interference, must trust in a given sense to: (a) the fact that the mass of symptoms and signs do not evidence an infection of the appendix; or (b) the tissues of the appendix are strong enough to resist the invasion of the germs; or (c) before the appendix is destroyed the germs will have destroyed themselves; or (d) the latter failing, a safe outlet for the pus will be afforded by natural means.

2. Medical means must depend upon the same arguments that have been advanced above for expectancy, plus the ability of drugs to favorably modify the course of the disease. It will be admitted, we believe, by the most ardent advocates of medical treatment of appendicitis, that they do not hope to sterilize the appendix, or kill its germs by direct means, and also that they do not attempt to provide a safe exit for the pus, but that their hope lies in ability to aid the resisting powers of the tissues to such an extent that their cells will win in the battle for life.

3. Surgical methods also fail to claim ability to sterilize the appendix *in situ*, fail to strengthen the resisting power of the tissues to any appreciable degree, and, in fact, confess that their only method of reliable action is by providing a safe outlet for the pus, and incidentally for the appendix itself.

It comes down then to medicine resting its superiority over expectancy upon its ability to promptly so modify the cell that it can win the battle, and on the side of surgery to its ability to promptly remove the disease without adding to the risk which the patient would bear by medical means. So much for the first line of thought.

Let us turn to the side of "clinical evidence." We are not aware that anyone has reported the results of pure expectancy in treating appendicitis, nor does there seem to be any like-

likelihood that such reports will be made in the future. Believing, however, that expectancy could be no *better* than medical treatment, we would be willing, for argument's sake, to concede to it somewhat more unfavorable or even the same results.

When we take up the consideration of the medical side of the problem, we are at once met by the most serious difficulties. First of all, reverting to our theoretical ability to so alter the cells either of the whole body or the appendix that they can withstand the germ-disease, there is grave doubt whether we can do this with the promptness and certainty which makes medicine available as a method of treatment. Even if we admit both the power of drugs to exert an antiseptic influence on the intestinal contents, and also the law of similars, it must, on the other hand, be admitted that antiseptics of the intestinal tract is of no value, for the inflamed appendix is, in most cases, already shut off from its intestinal communication; and also, that even the best prescribers are, in the present state of our knowledge, very frequently unable to put their finger on the similitum at once; that if three were watching the same case, each unknown to the other, it is doubtful if any two would prescribe the same remedy.

But, turning to the practical view, what has clinical evidence to say? Unfortunately it has very little to say upon the medical side of the question. Some years ago a prominent surgeon, after having published his statistics and been laughed at for advocating methods which have since been accepted, challenged the advocates of medical treatment of appendicitis to report in detail one hundred consecutive cases of appendicitis treated medically. No such report has ever appeared, so far as my knowledge goes, and it is said that every man who has made the attempt has become converted to the surgical treatment before his twentieth case. In other words, while men have reported isolated cases of cure, they have never reported any number of consecutive cases in which reliance was placed upon medical treatment alone. The only figures which we can give are estimates, and probably the best are those given by Morris in his valuable monograph upon this subject. He estimates that of his series of one hundred consecutive cases operated, with a mortality of 2 per cent., at least 25 per cent. would have died under purely medical treatment. Even if we were to

allow that the enthusiasm of the surgeon made his estimate *twice* too high, there would still be a balance of ten cases in a hundred on the side of the surgeon.

But all this is old ground. The physician admits that many of his cases must go to the surgeon, but he, and I am sorry to say the surgeon also, still claims the prerogative of deciding which is the surgical and which the medical case, and of discussing the question "When to operate for appendicitis." We must say that we consider the surgeons largely responsible for this state of affairs, in one of two ways: either they have mastered the technique of operating for appendicitis so poorly that their mortality is difficult to distinguish from that of medical treatment, or else, lacking the courage of conviction, they have catered to time-honored custom by making a display of so-called "surgical judgment" which must have cost many a life. The author would confess that having had drilled into his very being certain dicta as to the "operative" and "non-operative" cases, he has often sat down with medical friends at the bedside and gravely tried to decide *when* to operate; and that, looking over ten years of his own work and that of *confrères*, he doubts seriously the wisdom of postponing surgical interference in any but the rarest cases. He is sure that of the only two cases which he has lost, one lost his golden opportunity while the attending physician and the surgeon were discussing the advisability of operating, while the other died because the surgeon feared to do more than open the abscess.

We believe that the question of the selection of a method is already settled, and, furthermore, that the time to operate is as soon as safe preparation can be made after even a probable diagnosis has been reached. The grounds for this belief are as follows:

1. The uncertainty which always exists, despite the most careful weighing of symptoms and physical signs, as to the exact condition of the appendix.
2. The uncertainty which always exists as to the physician's ability to favorably influence the progress of the case by medical means, this uncertainty being demonstrated both by theoretical argument and clinical evidence.
3. The fact that (barring possible rare exceptions) in any stage of the disease and with any condition of the appendix a well-

planned operation by a skillful surgeon, experienced in the best methods of operating for appendicitis, will bring greater ultimate safety to the patient than any method of medical treatment in the hands of the most skilled physician.

The first two propositions afford little ground for argument. Let us state the evidence supporting the third.

In any given case of appendicitis one of two conditions must exist: either the appendix is free from pus, gangrene, or perforation, or it is the site of pus, gangrene, or perforation—there can be no middle ground, no third alternative.

Considering, first of all, those cases in which the appendix has been or is the seat of so-called catarrhal inflammation, either during the attack or in the interval, in the absence of pus we must agree that a competent surgeon should be and is able to remove the organ in a hundred cases without mortality. We admit the possibility of *accident* in any class of operations, but our statement applies to the work of conscientious skilled men, who will not undertake major operations without the proper precautions, and without providing against accident in the most approved manner. (The statement does not apply to beginners, nor to men who still retain the methods of twenty, ten, or even five years ago.)

Under these circumstances, and with these qualifications, the mortality will not reach 1 per cent.

The other class of cases are those in which there is pus, perforation, or gangrene present, and they will vary all the way from the patient whose appendix is the site of a small collection of pus, and in whom the "walling off" process is well established, to him whose appendix has ruptured, and the pus occupies such a large portion of the abdominal cavity that it is commonly called general septic peritonitis. This class will also include many moribund cases whose chances are very poor at best. It is here that both the physician and surgeon will now and then meet his Waterloo. It is here that we sometimes realize that Hahnemann's dictum as to the physician's duty expresses an ideal so lofty that neither the physician nor surgeon can attain it.

Speaking first of the cases which are moribund, or very nearly so, this is the class which has in the early history of surgery of the appendix most frequently come to the surgeon. It

is the class from which, we regret to say, the physician has most often drawn his picture of the results of surgery. This state of affairs has happened in the following manner: The physician has treated his patient until recovery, if the case progressed favorably; but if it did not progress favorably, he has considered consultation for twenty-four hours or more, and then consumed a few hours more in getting his consultant, and if the case was not at that time desperately sick, the surgeon, all too often, has, either out of consideration for his friend or for some other reason, postponed operation for another twenty-four hours.

Many surgeons have become fearful of being called "too radical," "too enthusiastic," unless they spend some time in making a decision. But even under these circumstances the operative route is the safer, even though its mortality is high and the moral effect of losing a patient after operation is more profound. If a patient is dying from the presence of pus in his abdomen, medicine does not offer him the shadow of a hope beyond the possibility of the abscess rupturing; on the other hand, surgery does; and desperate though his chances may have been, many a man walks to-day whose life was saved by the timely evacuation of pus from the abdominal cavity.

By far the more important cases are those in which there is pus, perforation, or gangrene, and yet they are apparently not sick unto death. In the earlier pages of this paper we have spoken of the view of these cases which must be taken by the physician, *i.e.*, they must be classed with other pus collections in the human body, and he *must* admit that his power over them is at best remote and uncertain. It is true that the pus *may* find a safe outlet—that it *may* remain encysted till the germs all die; nevertheless these results cannot be certainly and promptly accomplished by medical means. Even if either of these happy results take place, there still remains a damaged appendix, which in 80 per cent. of cases becomes the seat of another attack.

By surgical means, on the other hand, these cases are very safely handled. We have found that the danger of clearing out a pus-sac in the abdomen, breaking the abscess-wall apart, thoroughly disinfecting and draining the abscess, removing the appendix and closing intestinal perforations is not nearly as

great as was formerly supposed. All that it requires is practice, intelligence, and a thorough knowledge of available methods.

The surgeon who has a good technique opens the abdomen by a sufficiently roomy incision, takes infinite pains to wall off the general abdominal cavity by packing around the abscess many layers of sterile absorbent gauze; he carefully fingers a small opening into the pus-sac, allowing the pus to flow only a few drops at a time, and catches these few drops on sponges, which are immediately thrown away. As soon as all the pus which will flow is cared for, he opens the pus-cavity freely by separating the elements which make up its wall and disinfects the cavity with some strong non-irritating disinfectant. He removes the appendix in every case, unless the patient's condition is so serious that he cannot take sufficient time, and in this case he goes back after the appendix as soon as the patient's condition permits. Having done this, he drains the site of infection in a sensible manner—not by stuffing it full of poorly absorbent gauze, but by introducing one or two rubber-covered drainage-wicks made of the most highly absorbent gauze which can be procured, and being sure that their outer ends are well buried in a large mass of gauze of high absorbent power. In this manner is established a suction apparatus which will produce currents from all over the peritoneal cavity toward the wound, and which will as surely protect that cavity from infection as the surgeon is sure to keep unsaturated gauze at the outer end of the wick.

Notwithstanding the great fear which both the physician and surgeon have of operating *during* the attack, when, it is said, the peritoneum is inflamed, and therefore most liable to infection and least tolerant of handling, there is not one scintilla of evidence that we should "wait for the interval." As a matter of fact, very many of our abdominal operations are done in the presence of a local peritonitis, and it has never been shown that, aside from the greater risk of infection from the proximity of pus, there is greater likelihood of general peritonitis. Nor does it seem reasonable that the very process by which nature protects the general peritoneal cavity from infection should lower its resisting power. Is it not by means of peritonitis that she forms a wall about the infected region? We believe, in fact, that the inflamed peritoneum is unusually resistant to infection, and this

belief has support in clinical evidence, for it is a trite saying among operators that the simple, easy oöphorectomy is about as liable to result in peritonitis as the tough operation in which pus is handled. When considering whether to operate a given case now, during the attack, or wait for the interval, we must not forget that, however well the patient may be doing at present, he cannot reach the interval without a risk, and oftentimes this risk is as great or greater than that of the operation.

Our conclusions, then, based upon theoretical considerations and supported by clinical evidence, are :

1. In appendicitis we have a condition, the exact severity and dangerous nature of which does not appear in a given case at a time when that knowledge is of practical value.

2. That the organ affected is, so far as now known, not only useless, but peculiarly liable to disease.

3. That the medical treatment must, upon theoretical grounds, base its claim to consideration largely upon its power to so alter the cells of the subject that they are capable of overcoming the germs of infection.

4. That, while theoretical support to this claim seems to us at least rather remote, if we were to grant the claim there would still remain difficulties and delays in application of the method which would seriously weaken it as a practical method to be relied upon in treatment of a life-jeopardizing condition.

5. That clinical evidence has not as yet been presented which would place the medical method on a par, as to mortality, with surgical operation, assuming that the latter is performed by a competent surgeon.

6. That while the mortality of operation during the attack is probably greater than during the interval, still the *comparative* mortality, either during the attack or in the interval, gives a liberal balance on the side of surgical intervention.

7. That there appears little or no ground for the prevalent fear of disturbing an inflamed peritoneum by rational surgical procedure.

8. That, with the possible exception of very rare cases, we believe the time to operate appendicitis is as soon after the diagnosis as proper preparations can be made.

THE PREVENTION OF PULMONARY TUBERCULOSIS.

BY EDWARD R. SNADER, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of Pennsylvania.)

THE prevention of pulmonary tuberculosis begins, or should begin, in the spermatozoa of the grandfather or the fecundable element of the grandmother. To prevent disease by the control of hereditary influence is a method so ideal that we can never even hope to be able to dominate this causal element. No set of laws could be framed that could by any possibility of means specifically and positively control this one factor, and if rigid laws were framed they would never be enforced. Fortunately, according to modern medical investigation, direct heredity is a cause of pulmonary tuberculosis in only a very small proportion of cases. An enormous number are, therefore, acquired. This is particularly true, if we accept the theory of the bacillary origin of the disease. There are those among the medical profession, however, who, while giving adherence to the theory of the causative rôle played by the bacillus of Koch as the most credible working hypothesis extant, yet firmly believe that the soil has far more to do with the development of pulmonary tuberculosis than the seed. These observers, too, are of necessity, in view of the ideas they entertain, not pleased that the causative culpability of hereditary influence should be so summarily disposed of by the modern statistics showing that ante-natal elements are so minimally represented as an etiological factor in the production of phthisis. They know that the soil must be made ready for the seed. They know that the soil may, if the seed cannot, be transmitted. The statistics do not deceive these broad-viewing observers. Where ever they can they prevent the marriage, not only of the already tuberculous, but of those likely to become so. If we knew with mathematical certainty what the tuberculous diathesis really is, we would certainly be in a position to do more than we now do to prevent the marriage of unsuitable persons. But just what this inscrutable something

is that dominates cell life and makes a tuberculous soil no eye has yet been keen enough to see and no microscope powerful enough to reveal. Of course, we describe several constitutional states and bodily habits that we feel tolerably certain about. But, what percentage of those who look typically able to develop tuberculosis on the slightest provocation actually develop the disease? Think for one moment. How many of your phthisical patients actually present these classical landmarks of the phthisical tendencies? You have, it is quite true, seen some of these characters develop *pari passu* with the evolution of the disease, so that you sometimes wonder whether the disease itself did not develop the conditions of diathesis, rather than the disease develop on the diathesis, in these particular instances. Knowing so little, then, of the characteristic peculiarities of those who present the proper soil for the development of consumption, and seeing how frequently those escape who are typically entitled to do so by virtue of their constitutional habits, we are compelled to go about our prophylactic work somewhat blindly. We must be on the broadest possible kind of ground. That "broad ground" means that everyone who is at all ill must be made well, if possible. To bring about this desirable end there must be a complete change in the medical profession. We must know more about medicine in its broadest, deepest, widest sense. Every general practitioner must be more of a specialist, and every specialist must be more of a general practitioner. We must teach the public that the presence of disease does not necessarily imply that the individual is obviously ill. We must teach the laity that it is a crime for them to decide for themselves that they need, or do not need, treatment. When the public are thus taught, we will be able to help that vast army of patients who come to us occasionally, whom we feel certain need to be cared for medically, and yet are to the eyes of most lookers-on in perfect health. When the community, individually and collectively, ceases to be its own doctor, the medical profession will learn more of the actual nature of constitutional states that precede not only the development of pulmonary phthisis, but of other malign maladies. When the eyes of both the profession and laity are opened, and the doctors are more learned and strong in the power that knowledge gives them, all the medical text-books will have to

be re-written. How much we would all give if we could express to each other in intelligible fashion the "something" we know about disease that has never been written in any book, nor told us, but has simply come to us from our constant contact with ill-health. A look, a touch, a gleam of the eye, an odor, a movement, or a something inscrutable, sometimes sheds a flood of light upon the condition of the patient. We often know that patients under our care occasionally, or perhaps permanently, are not well, but for the life of us we cannot make their cases fit into any text-book description of disease, or diathesis, or cachexia. We must know more, and then perhaps we will be able to theorize, formulate and precisionize more than now. Every ill person, then, should be under the doctor's care until well, and all should be held under suspicion. This is idealism, I know. But, pray, how much prophylaxis have we had from practicalism, so far as hereditary soil-making or soil-immunity prevention is concerned?

The next phase of the subject that naturally presents itself for consideration is the isolation of those suffering from phthisis pulmonalis, in order to prevent those who have not the disease from acquiring it. It must be frankly admitted, if properly analyzed, that the isolation theory is a brutally selfish one that would be enforced for the protection of the well against the ill, rather than with anything more than a faint hope that, in some inscrutable way, some poor devil might recover. The isolation of sufferers naturally implies that the cases shall be discovered; but, in order to be discovered, they must be diagnosed, and then reported. Reported to whom? Why, the health authorities, you say. What health authorities? Those only in one, or at best two, of the larger cities of the Union. Any effort to be successful would have to be practically universal, and consequently at the very outset of the work of isolation there would have to be an inauguration of a series of municipal, borough, township, hamlet and country-side laws to assist us in securing this desired isolation. Before this could be done the general public would have to be educated up to an appreciation of the gravity of the situation; and it is reasonable to suppose, if we take into consideration the time it usually requires for a sanitary notion to take root and grow in the cerebral cortex of the average layman, and then multiply that

by several million, that it would not be an estimate drawing too largely on the imagination to say that the medical millennium will have come and gone before this creation of a proper sentiment in communities could be accomplished. There is only one way out of this difficulty, and that would be for the doctors to make the health laws, which Heaven forefend! We are by no means united, and the advancements of science and knowledge compel us to alter our front in the most chameleon-like fashion. We are never long united; and even the very idea of isolation, or rather the suggestion of its utility, is a legitimate offspring of the germ theory of the origin of pulmonary tuberculosis. There are several missing links that must be discovered and demonstrated before even the majority of physicians will accept the theory in any other light than that of a simple working hypothesis, whose reason for existence may pass away day after to-morrow and be superseded by another more fascinating or convincing theory. Admit, however, that isolation is right, and that it could be fairly well carried out, that isolation must of necessity be preceded by a diagnosis of the disease for which the sufferer is to be isolated. Just here is the rub. I shall now make a statement that may seem dramatic and startling. My experience as a physical diagnostician teaches me this point: Eight-tenths of practicing physicians do not know how to diagnose phthisis pulmonalis. The vast majority of consumptive patients do not arouse even a suspicion of the nature of their malady until the red flush of hectic has planted its crimson signal of "no surrender" upon the malar eminences. Until this disastrous period has arrived, then, these patients for one, two, three or four years have been spreading infection, atomizing the surrounding air with bacilli, spores, ptomaines, staphylococcal and streptococcal pus, with every cough. Isolation, to be of great practical service, must be begun at the earliest possible period. As a step in the forward movement we will have to reform our ranks, so that the disease may be recognized at a safe period. That innovation will be indeed a most valuable and practical contribution of the medical profession to the cause of healing and humanity. But, suppose we can diagnose the disease in the earliest infancy of its onset, when shall we isolate and whom shall we isolate?

That "whom" and "when" is another rub. If you will

think for a second seriously, you will come to the conclusion that there is not one family in a thousand who, either in its direct or collateral branches, has not lost one or more members from the fell destroyer, the "white death." If we believe in this idea of isolation with the firmness of the Cæsar who sacrificed his son to the principle of right, we shall have to tear a babe from its mother's arms, a wife from her husband, a husband from his wife, a child from its parents, ruthlessly and unflinchingly, mercilessly, brutally, and sometimes, too, at a period when the sufferer is not an invalid, and has possibly years of useful or fairly useful life before him or her. Is a consumptive a virtual leper? If so, at what period of time does he become so? When, if ever, does he cease to be so? If it were an arbitrarily fixed and unchangeable law that all tuberculous patients must be isolated as soon as discovered, before you would issue a fatal sentence of expatriation from all that makes life tolerable and happy, and places the patient where he or she may be made worse by concentrated infection, think a good while and hope more. You would think of certain dead-house revelations. How many patients have you seen on the post-mortem table and in the dissecting-room with the healed lesions of phthisis pulmonalis? What a revelation! Consumption of the lungs, then, does recover spontaneously sometimes? and probably in many more cases than die from the disease. What an affront this is to the awful pessimism that exists in the medical profession about the curability of phthisis pulmonalis. If nature can cure, why not art? We certainly, if we have any right whatever to an existence as a professional body, have helped nature before in other diseases, why not in this one? You may say to yourself that this course of reasoning is all sophistry, born of sympathy; and you are right; but just as surely as your sympathies are touched by a victim in your own family or in one of your beloved families (or possibly in any of your families), these sympathetic sophistries, as you may please to term them, will come to your minds, and you will be as human as you have often been before when the boards of health have stood between you and your patients.

You will be enforced in your disobedience against law, too, perhaps, by reasoning that law is made for the majority, and not for the individual, particularly for your individual. You

will, in imagination, see some poor, condemned consumptive shake his feeble fist at you, saying: "You have condemned me to exile to protect yourself. You think you are safe, now that I have been stamped as a leper and unfit for human society. You are but an atom safer than before, for there are tens of thousands like me who are pouring forth poison till it invests you all as an invisible cloud. When you condemn me you should find all and should condemn all. You think you can stamp my disease out by stamping me out. You cannot kill all the germs of my disease any more than you can those of other diseases that are as bad or worse than mine. Learn to cure the disease. If I must go, send all those with me who have ever come in contact with me since I had the disease. Hound them all out, whether sick or well. My contribution to the possibility of spreading consumption is only as a little mote in a sunbeam. Remember that equal justice demands that I shall be protected just as much as you are. Send away with me the sufferers from tubercular synovitis, fistula in ano, Pott's disease of the spine, tubercular disease of the bones, testes, ovaries, bladder, kidneys, liver, pleura, and the meningeal cases, if they last long enough. Be sure to send all the questionable glandular hypertrophies along. Find everything that bears the slightest resemblance to tuberculosis, developed or undeveloped, and all you suspect are liable to develop it, and deport them too. By that time your population will be so decidedly thinned out that the number of germs remaining (for you cannot by any possibility of means dream of destroying them all) will be so many for the extent of population that you will all soon pass away in death in your 'protected' communities. We poor wrecks and lepers will outlive you all."

This may be called a fanciful picture, I know; but just the same it stands to reason that a law to be effective must be universal in its application, and to be operative must be enforced, and the law would not and could not be universally enforced. You would individualize, and while you are a doctor and a scientist, you are also a man and human. Besides, laws were made for man, not man for the law.

If, then, it seems next to impossible to do anything more than limitedly control the development of pulmonary tuberculosis, from an hereditary standpoint, and for the many reasons stated,

to make the principle of isolation practically applicable only to a minimal extent, it follows that our greatest hope of preventing the development and spread of tuberculosis must be in the care of the individual, and through him of the community, aside from the manifest benefit derivable from hygiene, disinfection, and personal and care-taking sanitation—must be in the way of making the soil unsuitable for the seed, for the seed we have always with us, and always will have. But you cannot grow a rose on a rock, and if you have no soil you will have no tuberculosis, no matter if the air swarms with the micro-organic cause. We are not certain of the special kind of soil that the bacillus of Koch loves, and therefore we must assume that all ill-health predisposes, more or less, to the disease. We know, too, that the soil does change by natural means, for we have seen the dead-house revelations of cured phthisis. There can be no doubt whatever that much can be done to alter the soil that predisposes to phthisis. While medicines will doubtless be of great service in this work, proper food, light, air, sunshine, rest, exercise, and the observance of the laws of personal sanitation, must be at the very foundation of any rational attempt at prophylaxis against this dire disease.

This proposition by no means implies that we are to relax by one iota all just, legitimate and practicable methods of germ-killing and the prevention of infection, for we cannot hope to correct all soils any more than we can hope to destroy all germs and their products. Very often these preventive measures are one and the same with the soil-correcting means. Often both methods will pull in harness together as yokemates in the good work.

This scheme of prevention will require an enormous amount of work on the part of the doctor, the nurse, the layman and the governmental authorities.

We must teach the housekeeper that dust is an abomination of abominations in a sanitary sense; that a wet cloth is the superior of a broom; that rooms unaired are breeding-places for germs; that ventilation is as important as proper heat; that good food, properly prepared, is essential to health; that rugs are better than carpets; that heavy hangings at the windows are harboring-places of infection; that the condition of

the water-closet is of more meaning from a sanitary outlook than the appearance of the parlor; that sunshine and fresh air are life-principles; that the bath-room is a place where devotions are offered at the shrine of personal hygiene, and that, if "cleanliness is next to godliness," they can get there every day cheaply and pleasantly; that the home is a man's castle, and that it ought to be protected from the germ-enemies that are far more malign than any human foe.

We must teach employers that the health of their employees is in many instances largely in the employers' keeping; that where much dust is of necessity disengaged and kept floating in the air, the employees should be made to wear respiratory protectors over their mouths while at work; that the rooms must be ventilated; that extremely young persons should not be given employment; that holidays increase the working capacity and healthfulness of the employed; that good drinking-water and other sanitary necessities be attended to; and that they can get some pointers from the housekeeper that will make them philanthropists of the first water.

The authorities must take care of the indigent sufferer from phthisis, both on the grounds of humanity and sanitation, either isolated from other poor patients or not; they must make and enforce laws against milk and food contamination, and provide for the inspection of all products sold in the public markets that are known to harbor or can be suspected of harboring deleterious germs; they must institute competent inquiry into everything from a sanitary or food standpoint that will in any way whatever assist in the better prophylaxis of disease; they must give protection to the physician in the carrying out of sanitary instructions, and at the same time give him the largest possible field for the exercise of individual judgment; they must prevent the discharge of patients from sanitariums as cured when they still have bacilli in their sputa (*i.e.*, when the germ theory has been proven to be indubitably correct, but not till then).

The parent must be taught that a head crammed full of information at the expense of long hours in the school-room is paying very dear for a whistle; that a Brobdingnagian head on a Liliputian body is a gold-cornered invitation to phthisis; that exercise in the open air is of more importance than the rule of

three; and that the municipality that orders physical exercise given to girls or boys indiscriminately, without a request from the family doctor, is a prey to the machinations of some crank on physical culture whose instructions, if followed out without individualization, will indirectly kill ten where it helps one; that much home study is likely to lower the vitality at a time when the strength is needed to build a body fit for the mind and soul to live in; that an education, so-called, that attempts to train the mind at the expense of the body is a saving-at-the-spigot and wasting-at-the-bung-hole policy, and leaves the student a fit subject for any disease, consumption included; that the school-rooms and appointments must be in the highest degree sanitary; that the lunches in the school-room should be forbidden; that the Italian vender of hokey-pokey and pretzels, with his dust-covered wares, should not be patronized; that an easily-erect attitude be insisted upon at desk; that the time for recess should be extended and the actual period in the school-room shortened; that so long as the doctor is not satisfied with the physical condition of the children they should remain in the physician's care, whether in or out of school; that colds are dangerous; that bronchitis is not a simple disease.

Nurses, lay or professional, must be taught that the presence of dirt of any kind is a venial sin, but that neglect of the rules of sepsis and antisepsis is a crime for which there is no pardon; that a "stuffy" room is a disgrace, and that fresh air and sunshine in a sick-room are essentials; that their own health requires a daily outing; that to fail to remove discharges of any kind, sputa included, endangers everybody and themselves; that a room atomized by pus and other germs and spores may be very dangerous, although it smells sweet.

Both doctors and the laity must learn that lung quiescence predisposes to phthisis; that properly executed breathing exercises are as essential to bodily health as the morning prayer is to the moral strength, and that all stoop- or round-shoulders be prevented or corrected; that so-called athletics are a delusion and a snare, and directly lay the foundation of disease (and especially phthisis) by destroying the health-trinity of a sound mind, a sound body, a sound soul, by overdeveloping the muscles at the expense of the nervous system, thus deranging the balance in the trinity; that exercises should never go

beyond the plane of slightly stimulating the normal functions; that the undue consumption of food predisposes to phthisis by overworking the body's sewers to eliminate waste; that improper drinking of alcoholics predisposes, not only to phthisis, but to other affections nearly as bad, but for which the law will not attempt their isolation; that sunshine in the living-room by day and air night and day are the first two commandments of the gospel of health, and that temperance in all things is the third, cleanliness the fourth, and that there are more than ten of these commandments, some private, particular and individual, that only you would know about, that must not be violated.

Physicians particularly must learn practically that any lesion anywhere in the respiratory tract, from the nasal entrances down to the air-cells, must be corrected, even if it be only a so-called simple catarrh or a few adenoids; that mouth breathing is a sin in a sanitary sense; that bronchitis often lays the foundation of phthisis; and that a bronchial inflammation should not be considered cured because the patient no longer coughs, but that the condition of the bronchial mucous membrane sends out an invitation to any disease, but consumption of the lungs preferably, just so long as the membrane is unduly moist; that the doctor will tell the patient when he is well of a bronchial inflammation, and not the patient tell the doctor; that all pulmonary diseases, whatsoever their nature, should be screened from possible contact with the tubercle bacilli; that they will not treat a case of croupous pneumonia in the hospital in a cot next to a sufferer from phthisis unless you want to produce a case of mixed infection that will terminate fatally, in the interest of science; that all blood diseases send much of their contamination to the lungs, and hence predispose the patients to phthisis by lowering the vitality of the pulmonary tissues; that rheumatism and its consequent endocarditis is to be guarded against, for acquired valvular disease of the heart, by causing pulmonary backwash, directly predisposes to phthisis; that diseases of the liver, by loading up with waste, predispose to consumption; that intestinal auto-infection, so-called dyspepsia, anæmia, constipation, deficient kidney elimination, all are soil-producing factors that may, neglected, produce phthisis; that all the constitutional diseases are seed-

inviters, and that measles, whooping-cough, typhoid fever, bronchitis, la grippe, and any of the pneumonias, bear a specially close relation to the development of phthisis, both by soil-making and seed-inviting properties.

If you have followed me closely in the consideration of this subject, gentlemen, you will have perceived that I do not regard the medical profession as being as yet in a position to decide upon absolutely the best means to be pursued in preventing pulmonary tuberculosis. I believe, however, that we are able to affirm that in some instances, and along some lines, we shall be able to accomplish a not insignificant work in the prevention of phthisis. To cure, however, is the ideal, and that will be the greatest kind of prophylaxis. But in order to cure we must diagnose the disease early.

Prevention of the "white death," I am sure, will never be practically accomplished through any one channel, but only by making a multiplicity of influences tend toward the same end.

THE RELATION OF PATHOLOGY TO HOMŒOPATHIC THERAPY.

BY CHARLES MOHR, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

A RECENT writer in the *Journal of Medicine and Science* says of Hahnemann that to him "belong, with other things, the theories of similars and infinitesimals in therapeutics. Apparent symptoms were made the groundwork of treatment, and a knowledge of pathology was considered unnecessary. The term 'symptom,' without reference to a condition causing the manifestation, is a meaningless misnomer; and symptoms, so-called, without proper reference to an underlying condition, are necessarily poor guides for any treatment which, properly directed, would be of value. The system has seemingly shown a wonderful tenacity of life, but the strength of endurance has been more apparent than real. The name of the system remains principally as a trade-mark in business, while the original practice has mainly departed. It is possible, however, that some adherents to the system may still be found so far in the

rear as in practice to hold to the original tenets of the school, but to find them is hardly worth the searching. The term 'new school,' which is sometimes heard, is here a ridiculous absurdity."

It is thus that "our friends, the enemy," speak of homœopathic practitioners; and little wonder, as there are so few of the latter willing to stand by their colors. Indeed, one frequently hears, in our own society discussions, slurs on those who still believe and practice according to Hahnemann's tenets, as though they were little more than "symptom coverers."

Hahnemann attacked the pathology of his day, as well he might, as an indication for medical treatment, and hurled his anathemas against the prevailing habit of forcing "the evacuation of some material morbid substance, as well as of several kinds of fictitious humors, alleged to form the basis of diseases." (*Organon*, p. 23.) Hahnemann did believe in "sick physiology," but he did not believe in the theoretical explanations offered by the pathologists of his and former days as to the changes in tissues, fluid and solid, which were the cause of the various diseases of mankind. He denounced "revolutionary (revulsive) treatment, *possessing no direct immediate pathological bearing upon the structures primarily affected.*" (*Organon*, p. 29.)

When Hahnemann saw how vague the shifting theories and hypotheses of the pathologists were, and how pernicious the means employed to cure the sick; and, later, when he had satisfied himself that there was a law of cure, expressed by the well-known Latin formula *Similia similibus curantur*, and under the law advised his followers to treat likes with likes (*Similia similibus curentur*), his aim was to insure simplicity and certainty.

Hahnemann was himself a theorist—we admit this; but above all he was intensely practical, and to him a fact was always a fact. If a drug was capable of curing a patient of a disease once, it was capable of curing any number of patients at any and all times, provided always the symptoms and conditions were identical.

Hahnemann did not, as the writer of the article quoted, ignore *conditions*. Indeed, any one familiar with Hahnemann's works finds abundant evidence that such was not the case. What more plain than his assertion in § 70 of *The Organon*, that a physician must regard as curable in diseases "all the complaints

of the patient, *and the morbid changes of his health perceptible to the senses.*" In §186 local diseases are referred to, and affections of external parts requiring mechanical skill, properly belonging to surgery, and in cases "when external impediments are to be removed that prevent the vital force from accomplishing the cure. Examples of this kind are: reduction of dislocations; the union of edges of wounds by bandages; the extraction of foreign bodies that have penetrated parts of the body; the opening of cavities, either for the removal of cumbersome substances or to form an outlet to effusions; the approximation of fractured ends of bones, and the retention of the adjusted parts by proper bandages, etc." In §192 we find Hahnemann saying that the homœopathic medicine to act effectually on acute local disease must be selected "by conducting the examination of a case in such a manner that the record of the exact state of the *local disease* is added to the summary of all symptoms and other peculiarities to be observed in the *general condition* of the patient."

It seems to me this is getting at the pathology pretty thoroughly, and is the method employed by all practitioners of Hahnemannian homœopathy who are deserving of the name. I know there are physicians of our school who rightly believe that the anatomical lesion alone gave no indication for drug therapeutics in Hahnemann's philosophy; and there are others again who wrongly believe that the subjective phenomena were all that Hahnemann took into consideration in treating the sick.

There are still too many homœopathic practitioners who make a single objective symptom and its nearest organic origin the basis of therapeutics; they endeavor to match an anatomical structural change by a drug supposedly capable of producing a like pathological product. They apply the remedy to a disease rather than to a patient. Witness the too common practice of prescribing *phosphorus* because a patient has an inflamed lung. Similarities like these are alluring, but the fascination leads men to follow Paracelsus and Rademacher rather than Hahnemann. It is far better never to rest content with identity of lesion, or with identity of seat between disease and drug; we should aim also at making their kind of action the same, and this can only be done by securing similarity in their symptoms and conditions.

Then, again, we find other practitioners of homœopathy satisfied to prescribe, on some one peculiar subjective sensation, a drug, the pathogenesis of which shows an identical peculiar subjective sensation. Hahnemann himself cautions us in the *Organon* against being misled by such persistent single symptoms, however peculiar or individual. Sometimes, too, a prominent and peculiar symptom is the result of some removable cause, and no matter how near the symptom is matched by a drug, it continues until the *cause* is removed. The drug was not indicated. Hahnemann taught us to remove the cause by whatever means were necessary.

Misconceptions in the application of therapeutics would be readily removed if physicians would properly estimate the meaning of terms. Ordinarily Physiology is defined as the science of health, or normal life; Pathology as the science of disease, or abnormal life; and Therapeutics as the science of curing diseases. Generally, if the physician of the ordinary kind cannot demonstrate the *physical* presence of something abnormal, he concludes that there is no disease, hence no need of therapeutics; and generally, again, if the physician of the ordinary kind can demonstrate a lesion, he concludes that by adapting a remedy to the product of the disease he is treating the disease. To the well-qualified practitioner, who may be designated as the extraordinary physician, how different his efforts in the science of therapeutics if he believes, as Hahnemann did, in a pathology totally distinct from that which only recognizes pathological anatomy. He adapts a remedy to the totality of symptoms, even though, as is so frequently the case, no structural change in tissues or organs can be discovered by the means at his command; the symptoms may be altogether subjective. He treats a patient, not a disease. That Hahnemann and his true followers are not alone in the recognition of such cases, let us hear the words of a celebrated old-school authority. Dr. Russell Reynolds, before the British Medical Association, pleaded most eloquently as follows: "Is it not coming to this, that but little attention is often paid to the accounts which patients give of themselves, their ideas, emotions, feelings, and physical sensations? These are things which we cannot weigh in our most guarded balances; measure by our finest scales; split up by our crucibles; or describe in

any terms save those which are peculiar to themselves, and which we cannot decompose. These symptoms are often disregarded and set aside; and the patient whose story of disease is made of them is often thought fanciful, hypochondriacal, hysterical, nervous or unreal—because, forsooth, we have physically examined thorax, abdomen, limbs, and excretions, and have found in them nothing wrong; because we have looked at the retinae, examined the limbs electrically, traced on paper the beatings of the pulse, weighed the patient and not found him wanting. Still he is miserable, in spite of placebo and assurance that there is nothing organically wrong! There may be in him a consciousness of deep unrest; or of a failing power which he feels, but cannot see; or of something worse than pain, a sense of impending evil that he is conscious of in brain or heart; a want of the feeling of intellectual grasp, which he may call failure of memory, but which memory—when we test it—seems free from fault; a want of the sense of capacity for physical exertion, which seems, when we see him walk or run, to be a mere delusive notion, for he can do either well or easily to our eyes or those of others; and so he is called nervous, and is told to do this or that, and disregard these warnings which come to him from the very centre of his life. And let me ask whether or no it has not again and again happened in the course of such a history as that which I have only faintly sketched, that some terrible catastrophe has occurred? Do we not see minds gradually breaking down while we say there is no organic change in the brain?—hearts suddenly cease to do their work when, after careful auscultation, we have said there was naught to fear? Suicide or sudden death sometimes disturbs the calm surface of our scientific prognosis of no evil; we may be startled, and then may see all that we ought to have seen before. But when the ripples that such unforeseen events have occasioned on that smooth surface have subsided, we go on as we have already done, and still pay but little attention to what the patient feels, and delight ourselves in the precision of our knowledge with regard to physical conditions of which we may know nothing and may care still less. No one can appreciate more highly than I do the value of precise observation, but I do not believe that minute, delicate and precise observation is limited to a class of facts that can be counted, measured

or weighed. No one can see more distinctly than I do the wrong conclusions to which a physician may arrive by accepting as true the interpretations which fanciful patients may offer of their symptoms; but I am sure that if we pay no heed to those mistaken notions of a suffering man, we lose our clue to the comprehension of the real nature of his malady. Morbid sensations and wrong notions are integral parts of the disease we have to study as a whole, and we are bound to interpret their value for ourselves; but we can ill afford to set them aside, when we are as yet but in the dawn of scientific pathology, and are endeavoring to clear away the obstacles that hide the truths we hope hereafter to see more clearly about the mystery of disordered life. The value of such symptoms may be slight in some kinds of disease, when compared with that of those phenomena which may be directly observed; but we are bound to remember that there are many affections of which they furnish the earliest indications, and there are not a few of which they are throughout the only sign."

On the other hand, the extraordinary physician again, who recognizes that pathology is the science of morbid processes and functions, and that pathological anatomy is the science of morbid organs and tissues, is in a position to exercise the functions of the therapist most satisfactorily. He clearly recognizes the "totality of symptoms" and conditions, so much insisted on by Hahnemann as giving the indications for the administration of the "similar remedy." Take a pneumonia as a familiar example. What rational physician, what true homœopathist, would think of taking the structural changes in the lung alone as an indication for medicinal treatment? The morbid processes and deranged functions which present themselves give the true and unfailing indications for drug therapeutics. The fever, the flushed or red cheek, the rapid pulse, the relatively more rapid respirations, the chest pains, the painful cough with its bloody or rusty and sticky sputum, the delirium, the feeble heart with its distant heart-sounds;—all these, together with certain ameliorations and aggravations, are a complex of symptoms taken into consideration by the Hahnemannian prescriber, and to these he directs his therapeutic measures, giving that single remedy whose pathogenesis shows the nearest resemblance to the aggregate of the disease

phenomena. As it is with so common a disease as pneumonia, so it is with all other affections, whether of dynamic, infectious or microbic origin.

We may all profit by the sage remarks, bearing on the questions discussed in this paper, quoted from a celebrated old-school authority. Sir Andrew Clark, in his Presidential address before the Clinical Society of London, said: "Another great work of our society has been, and continues to be, the gradual unfolding of the exact relations which morbid anatomy and, incidentally, experimental pathology, should hold to clinical medicine. These two servants of our art, excited and carried away by their marvelous successes, and assuming a joint sovereignty over our art, look down with a condescending superiority upon clinical medicine, ridicule her claims to supremacy, scoff at her empirical distinctions, reproach her with being unscientific, and strive to torture her into a slavish subjection to their theories. But the true relation is not this; it is, indeed, the converse of it. For the structural change is not disease; it is not co-extensive with disease; and even in those cases where the alliance appears the closest, the statical or anatomical alteration is but one of other effects of physiological forces, which, acting under unphysiological conditions, constitute by this new departure the essential and true disease. For disease in its primary condition and intimate nature is in strict language dynamic; it precedes, underlies, evolves, determines, embraces, transcends and rules the anatomical state. It may consist of mere changes of the relations of parts, of rearrangement of atomic groupings, of recurring cycles of vicious chemical substitutions and exchanges, of new conditions in the evolution and distribution of nerve force, and any or all of them may be invisible to the eye, inseparable from life and undiscernible in death. Undoubtedly the appearance of a structural alteration in the course of disease introduces a new order of events, sets in action new combinations of forces, and creates disturbances which must be reckoned with, even as mechanical accidents of the pathological processes. But always behind the statical lies the dynamic condition; underneath the structural forms are the active changes which give them birth, and stretching far beyond the limits of pathological anatomy, and pervaded by the action and interaction of multitudinous forces, there is a region teeming

with manifold forms of disease unconnected with structural change and demanding the investigation which it would abundantly reward. It is in this mysterious and fertile region of dynamic pathogenesis that we come face to face with the primitive manifestations of disease, and learn how much knowledge from various sources is needed to understand it aright; it is here that we see how, without help from physics, chemistry and biology, collecting, converging, and meeting in a common light, no single problem in disease can be completely solved; it is here that we are made to comprehend how the nature of a pathological product cannot be determined by its structural character, but by the life history of the processes of which it is only a partial expression; it is here that we observe how, in therapeutic experiments, the laws of the race are conditioned and even traversed by the laws of the individual."

In these later days much attention is given to the study of pathological anatomy and to experimental pathology, and this is as it should be; but there should be at the same time a proper estimation of the good such knowledge can be to the therapist, and homœopathic practitioners should least of all, as we have seen, ignore the value of all such study. On the other hand, much more attention than is given should be directed to experimental pharmacology. We want more provings, especially of the many new drugs introduced since Hahnemann's day. We want the provings conducted in such manner that no doubt can be entertained as to the validity of the pathogeneses published for therapeutic uses. In the study of pathology we want to know what is behind the disease product. In the application of therapeutics we must know all there is to treat, before we can apply a medicine.

CHRONIC DIARRHŒA CURED BY NUX VOM. 3.—A woman, 60 years of age, had suffered for five months from chronic diarrhœa; unsuccessfully treated allopathically, during this period. The evacuations were thin, mixed with blood, accompanied by severe pains, and frequent but fruitless urging to stool. The diarrhœa awakened her every morning at 4 o'clock. She was entirely cured by nux vomica 3. Three drops three times a day.—*Hom. Monatsblätter*, December, 1900.

PATHOLOGY IN RELATION TO THE THERAPY OF SPECIFIC URETHRITIS.

BY MACPHERSON CRICHTON, M.D., WASHINGTON, D. C.

(Read before the Washington, D. C., Homœopathic Medical Society.)

THE therapy of urethritis specifica has of recent years shown wide variation and material progress. Instead of treating the catarrhal process by astringents alone, as formerly, we now employ drugs that are purely antiseptic, or perhaps remedies that combine the antiseptic and astringent properties—those of the astringent variety being intended to diminish the hyperæmia and extravasation from the blood-vessels, while those with the antiseptic properties are to act directly upon the exciting cause of the disease, the gonococcus of Neisser. To obtain a clear insight into these medicaments we must first form a comprehensive picture of the gonorrhœal process, as well as the various relations of the cocci in the many phases of the disease, and therefrom draw our indications for treatment.

You will readily recall that the mucous membrane of the fossa navicularis is covered with stratified pavement epithelium, which is transformed abruptly immediately behind the fossa into glandular epithelium, which extends throughout the remaining portion of the canal. The epithelium of this latter area consists of four layers: 1st, a superficial layer of cylindrical epithelium; 2d, a layer of transitional cells; 3d, a cubical layer; and finally, 4th, a sub-epithelial layer of the connective tissue.

The gonococcus upon entering the urethra at the moment of infection advances over the area of the flat epithelium, perhaps entering the intercellular spaces, but failing to penetrate deeply, as this form of epithelium resists in a great measure the gonococcic invasion. When, however, the gonococci have passed to the region posterior to the fossa they have no longer to contend with the flat epithelium which is inimical to their progress, but now come in contact with the cylindrical cells; the condition is at once changed, the gonococci not only growing and thriving here on the surface of the canal, but, penetrating between

the cells, multiply within the intercellular spaces, and finally force themselves between those of the cubical layer, and in this way reach the uppermost layer of the connective tissue.

Upon the penetration of the epithelial cells by the gonococci the former become loosened; following this a desquamation sets in, and finally a mucoid degeneration results, the cocci now forming toxins which irritate the mucous membrane and cause a reactive inflammation, the blood-vessels of the sub-epithelial connective tissue become dilated, and extravasation of the blood serum with diapedesis of the corpuscular elements results, which elements rapidly become purulent in character, owing to the infection. In association with extravasation and diapedesis the polynuclear leucocytes are thrown out. These wander toward the surface of the membrane, penetrate the epithelial cells and intercellular spaces, and in this way come into immediate contact with the cocci. Upon the approach of the polynuclear leucocytes the gonococci change their course, and, ceasing to penetrate the tissue further, advance now at once upon these leucocytes and become merged in their bodies.

It is to be remembered it is essential for the life of the coccus that it find nutrition, and that this is best obtained in the white blood-cell, though it may subsist upon superficial epithelium or superficial layer of the connective tissue. We now have a pus cell infected by and laden with the Neisser's coccus. The white cells here, however, are not to be considered an example of cell activity in the Metchinkoff sense. Nevertheless this process succeeds in eliminating the cocci from the deeper layers of the urethral tissues, for the pus cells so laden continue on their course to the surface of the canal, and become finally washed out by the passage of the urine.

Hence it is that though the white cells are attacked by the cocci they yet have the power to find their way to the surface, carrying the cocci with them, thus eliminating the causative factor, and so giving us in a measure a self-limiting disease. It is clear that the extravasation and diapedesis which occur upon infection through the connective tissue and epithelium to the urethral surface is of such a character as to actively resist the invasion of the cocci and energetically tend to establish a return to the normal, and in this way give us a spontane-

ous cure. The disease having reached the end of the third week in its progress, the pathologic picture is entirely changed. The connective tissue now shows wider dilatation of its blood-vessels, from which corpuscular elements and serum continue to flow; but the cocci are now either present in markedly decreased numbers or entirely absent. In the epithelium of the canal there is now established, with the idea of preventing anew the entree of the cocci remaining from the acute process, an epithelial metaplasia resulting in the formation of stratified pavement epithelium.

In this stage the cocci are found more or less superficially placed upon or just within the superficial epithelium of the canal, where they continue to cause inflammatory reaction and migration of the leucocytes replete with cocci, extravasation of the serum, and desquamation of superficial epithelium of the urethra.

In the spontaneous and normally progressive cases the tendency is, however, when no injury to the parts takes place, for the cocci to decline in number, the elimination of them being rapid, and in a portion of the cases the cocci disappear from the urethra at about the end of the sixth week. As the number of cocci decreases the inflammation diminishes; but should the patient for any reason suffer an injury at this time, such as sexual intercourse, pollution, alcoholism or secondary infection, an increase of the inflammation follows, due directly to a hyperæmic condition of the mucosa, resulting in a renewal of the exudate of pus cells and serum, followed by a separation of the epithelial cells and formation of crevices, into which crevices the cocci penetrate, and the inflammation manifests itself anew, resulting in a repetition of the former processes.

After this auto-infection the cocci remain for a longer period in the tissues, and another step in the pathology is inaugurated. Owing to the prolonged presence of the cocci within the tissues the mucosa adapts itself to the presence of the same, and their accumulated toxins, resulting in a decreased reactionary inflammation, each subsequent reaction being minor in degree, and, as a result, after the third or fourth relapse the cocci are not ejected from the tissues, by reason of this lack of reaction on their part; furthermore, the irritative action of the perma-

nently located cocci causes a connective-tissue proliferation and an infiltration of the mono-nuclear cells as a result of the destruction of the connective-tissue cells, and the process now becomes chronic. From this grossly portrayed pathology of specific urethritis one makes the division of the acute process into two stages, one in which the cocci are deeply placed, the other where they are more or less superficially situated. It also in a measure explains the relapses and the processes leading to the development of chronic urethritis specifica.

The clinical picture presented in both these stages corresponds closely to the pathologic condition during the first fourteen days; *i.e.*, by the time the coccic invasion of the epithelium and superficial layer of the connective tissue is considerable, we find the secretion consisting very largely of pus cells which, for the most part, contain the gonococci. Here and there we also find pavement epithelium from the fossa navicularis, and it is at this period that the manifestations of the malady are most acute, secretion the most profuse, being characteristically thick and yellowish-green, with micturition and erection most painful.

Immediately, however, the cocci are carried back to the surface of the canal the symptoms of the acute stage subside, and the case now reaches a second phase in which the secretion becomes milky, and pain on urination and erection ceases. This period is reached in the third week in cases of specific urethritis running a classical course.

On microscopic examination the discharge now shows not only pus cells with innumerable cocci, but associated with them are epithelium of the different types found in the urethra, which for the most part are of transitional and pavement variety, surrounded by free and thriving cocci. So soon as we can demonstrate by the microscope that the epithelium are encircled by the proliferating cocci, the metaplasia has commenced, and the process of repair sets in.

Finger, of Vienna, has shown many cases of specific urethritis capable of spontaneous cure—cases in which he has practiced the administration of placebo alone, with the exception of a little bromide and careful dietary—these cases going on to complete recovery and without leaving a gleet.

Therapy cannot, therefore, do much more than hasten matters when there are no aggravating factors present in the acute

condition. For the cutting short of the process we have the three classes of remedies named : 1st, the antiseptic non-astringents, such as mercuriol, protargol and largin ; 2d, the remedies at once gonococcidal and astringent, such as argonin, argentanin and argentum nitricum ; and finally, 3d, the purely astringent, such as the zinc sulphate, permanganate of potash and lead acetate.

The second class, while apparently ideal prophylactics, present distinct disadvantages, inasmuch as they contract the mucosa, and thus wall in, as it were, vast numbers of the cocci, which, lying deeply situated in the mucosa, cannot be washed out by the suppurative process.

Hence it is that astringents are contraindicated in the early stages of urethritis, and the non-astringent antiseptics, protargol, largin, etc., which, being soluble silver preparations, are most available ; for these remedies *do* penetrate for a slight depth, and could they but reach the bottom of all the urethral follicles, a few administrations would suffice to cure ; but their action is very deceptive, for, while they apparently bring about prompt cure, relapses are the rule on discontinuance of their administration. Other advantages of these remedies are their painlessness in administration, and the fact that they produce no sphincter reflex contraction.

One may add that for all these reasons the introduction of the new silver preparations constitutes what progress has been made in the local treatment of urethritis in the past few years.

In the second stage of the disease the antiseptic astringents are clearly indicated, whereas in the hyperacute condition the writer has found it well to discontinue all efforts at local treatment, and to rely upon the internal antiseptics, such as urotropin, salol, gonorrhhol, or upon the balsamics, until a diminution of the more severe symptoms will permit of the administration of injections. With these anatomic and pathologic principles underlying the therapeutic indications one can readily take hold intelligently of these three groups of therapeutic agents which one has at one's disposal, and prescribe on a thoroughly scientific basis for each of the foregoing single phases of the gonorrhœal process.

SOME OBSERVATIONS UPON THE EXAMINATION OF CHILDREN.

BY C. SIGMUND RAUE, M.D., PHILADELPHIA.

(Read before the Wm. B. Van Lennep Clinical Club, December 4, 1900.)

THE diagnosis of diseases in children rests mainly upon data obtained from a close observation of their onset and their clinical course, together with a recognition of the physical signs, and the evidences of diathetic disease or constitutional shortcomings that may be found in the case. As the physician becomes more familiar with babies, and learns to interpret their cries, grimaces, and various abnormal movements, and sees in the position assumed during sleep, and in the manner in which they take or reject their food, and in a host of other actions common to the babe in health and in sickness, a new language speaks to him, and he achieves such proficiency in the course of time that he diagnoses disease "by intuition," as the popular term has it. But this can come only from a large experience, as a result of painstaking interest and the closest observation.

The babe must be studied by himself; he is an individual not conforming to the canons of general practice. The fact that the babe is not endowed with speech, and so is unable to express his feelings and direct us to the seat of his trouble, would at first thought seem the main obstacle to diagnosis, and in this manner alone create the difference existing between diseases in children and in adults. But this is true to a lesser degree than is usually supposed.

Objective symptoms, or signs, are always more accurate and reliable than subjective symptoms, and a careful search for the former will seldom fail to establish a correct diagnosis without any reference whatsoever to subjective symptoms. And even when subjective symptoms can be elicited after the child has learned to talk, they are often more misleading than useful. It is true, many such symptoms if properly interpreted, are of the greatest importance, common examples being pain complained of in the epigastrium, leading to an examination of the heart and

pleura; or pain in the knee, to an examination of the hip-joint. But on the whole, objective signs, including the general appearance of the child, the diathesis, the condition of the nervous system, the state of the skin and osseous system, of the mouth and abdomen, and the character of the ejecta and stools, the state of the naso-pharynx, tonsils, bronchi, lungs and pleura, of the heart and blood-vessels, the liver and spleen, genito-urinary organs and urine, and the blood—the physical signs furnished by careful investigation of these separate systems, coupled with the history of the case, must furnish data from which an unassailable diagnosis can be made, providing they are logically interpreted.

To enter with any degree of thoroughness into the method of investigating the above-mentioned systems would command the use of far more space than the limitations of this paper allow, and so I shall confine myself to speaking only in a general way upon this special subject, which, although assiduously worked and mined by a vast array of past and contemporary investigators still stands a mine of unlimited resources, wherein there is for every worker his full compensation in nuggets and gems.

After having obtained the family history, we should inquire into the child's early history—the nature of the labor, the mode of feeding adopted, previous illnesses, the dates of teething, walking and talking, the state of the fontanelles. All these data are of especial interest. For example, if we are confronted by a child that is late in walking, and learn that it was artificially fed, subject to prolonged diarrrhœal attacks, followed by constipation, that the teeth came late and at long intervals, and that it sweats profusely about the head, it will hardly be necessary to search for further indications for rickets in the osseous system, especially as they may not yet be prominently developed. Or, having failed to find the signs of rickets in the osseous system, we are still justified in diagnosing the disease and predicting the ultimate course it will assume.

If we meet with an acute disease the mode of onset is of the greatest importance, and having located an acute condition, its true nature is often impossible to decide upon unless we recognize the diathesis underlying it. Thus, a joint inflammation associated with endocarditis can safely be considered rheu-

matic, and one associated with chronic enlargement of the lymphatics in various parts of the body, or with actual evidences of phthisis pulmonalis, must be looked upon as tuberculosis. I recall seeing a boy of about six years of age whose malady had been diagnosed as appendicitis because his right leg was drawn up and fixed, and there was abdominal tenderness and fever; a thickly coated tongue and severe pains in the pit of the stomach had been complained of. A careful examination showed that the fixed position was the result of a rheumatic inflammation of the knee-joint, which also explained the fever and coated tongue. The epigastric pains were accounted for by a marked endocarditis. Furthermore, both the previous history and the family history confirmed the rheumatic nature of the ailment.

A knowledge of the normal rate of growth and development is absolutely essential before we can judge of the progress the child is making, which is so important a guide in the recognition of certain constitutional diseases. This will also indicate the prognosis in acute illnesses to a great extent. One of the first indications of the onset of a serious disease, such as tuberculous meningitis, for example, may be the absence of the regular weekly gain in weight. Roughly speaking, the child's weight may be said to have doubled itself by the end of the fifth month at the rate of half a pound per week, and trebled itself at the end of the first year at a somewhat lower rate of weekly gain. While this regularly ascending weight-curve is a most valuable indication of good health, still it does not hold absolutely. Investigating in this line, Budin has recently observed that syphilitic children with a faultless weight-curve often die suddenly in the most unexpected manner, and in febrile cases of severe grades he has noted frequently an increase in weight. A sudden increase in weight has also been noted, as high as 250 and 325 grammes in three days, in children suffering either from localized œdema or suppression of urine. They died in the course of a few days, and he has come to consider a sudden and marked rise of the weight-curve during illness as indicative of a bad prognosis.

Having observed whether the growth and increase in weight has conformed to the normal standard, and noted the condition of the child's teeth, its fontanelles, joints, mental development

and general appearance, we must now decide whether we are confronted by a normal constitution, or one that has been tainted through heredity or undermined by previous illness or improper care.

To satisfactorily inspect the child we must have it stripped and view it from all sides, both lying and standing. There is too much of importance that may escape us if we fail to adopt this course. The various deformities of the head, chest, skin and extremities are classical, and I need not enter into their description. But I would say a few words upon the position assumed by the sick child. We see it cuddled up into a little heap and lying upon its side—an unusual position for a sick child—and we should not delay in examining the pleura on the side upon which it is lying. In the graver febrile disturbances, children, as a rule, lie flat upon their backs, and when we once more find them rolling over on their side we can augur a good prognosis. An interesting symptom observed in meningitis associated with the involvement of the spinal cord is the inability of the patient to extend the leg upon the thigh when in the sitting posture, owing to contraction of the flexors of the leg, this, however, disappearing when the dorsal decubitus is assumed. The sign has been named after Kernig, who first described it.

When symptoms of paralysis are encountered, it is very important to decide whether the non-use of a member is dependent upon actual paralysis, or upon a painful joint-affection, or some accidental condition, such as epiphyseal separation. Very often the pseudo-paralysis of rickets is confounded with actual paralysis; but this condition represents merely an extreme degree of muscular weakness and laxity of the articular ligaments, although in extreme cases inflammatory processes at the roots of the spinal nerves have been thought to exist. The well-developed signs of rickets should furnish the clue to the diagnosis.

In cases of broncho-pneumonia associated with great dyspnoea, the child may be found propping itself up in bed, every accessory respiratory muscle being thrown into play. But this picture is also encountered in croup, pleurisy with effusion, both acquired and congenital heart affections, and in asthma, a special examination being necessary to differentiate these

affections. Regarding the breathing, I would call attention to the characteristic alteration in the respiratory rhythm in pneumonia, which I consider of great diagnostic value. Normally, inspiration and expiration follow each other in rapid succession, after which comes a pause. In pneumonia, however, there is a pause immediately after the inspiratory act, and the expiration is short and thick, usually accompanied by a grunting sound. When the grunting becomes pronounced, it is said to indicate collapse of lung tissue. I would explain the peculiarity of the respiration on the ground that the child wishes to hold the freshly inspired air in its lungs as long as possible, and then quickly expires it in order to draw in a fresh supply of oxygen.

One word in regard to the cry. I do not wish to refer to the various characteristic cries with which you are all familiar, but I think the old and well-known hint that when a child cries continuously in spite of all that can be done to humor it and in the absence of all apparent causes that might account for the crying, we should strongly suspect earache. I have in several instances, to my chagrin, not heeded this bit of advice, and so utterly failed to either diagnose the child's condition or give it relief until the ear unexpectedly discharged and told the tale. Even though a child may be otherwise unwell, if its condition should not warrant the ceaseless crying, and fretting, and worrying, don't forget that it has ears and that children are very prone to earache.

Before leaving the subject of inspection I must refer to the physiognomy which frequently tells a plain story. Note the idiot, the epileptic, the face of Bright's disease, of cardiac disease, and of tuberculosis; and, last but not least, the deficiently developed upper lip and pinched nose resulting from the adenoid habitus. Not only do adenoids concern us in mouth-breathing, but they may induce asthma and enuresis reflexly, or be responsible for a flat, undeveloped chest and a frail constitution.

I would also dwell upon the importance of cultivating the eye to take in a picture at a glance and retain its images long enough to recall them before the mental eye and analyze them. This refers most particularly to throat examinations, where a single glance is frequently all that can be obtained without

doing the child positive injury, and I would advise putting off inspection of the throat as the last step in the examination, and also warn against the use of force and the avoidance of violent struggling on the part of the child in serious throat affections, where it is not absolutely necessary.

Palpation is a method of examination which gives much information in diseases of children. In fact, I may say it is more applicable in a general way and more essential in the proper routine examination of children than in adults. The sense of touch, with a little training, will immediately tell us whether we are confronted by a febrile disturbance; whether one particular part of the body be hotter than the rest; whether the skin be moist or dry; the body tender universally or only in certain localities. Through palpation we can frequently learn as much as through auscultation in thoracic disturbances, for the child's chest-wall is so thin and pliable that bronchial and pulmonary râles and cardiac thrills may be felt and even differentiated as satisfactorily by the sense of touch as by the ear.

The abdominal viscera are usually more accessible to palpation in the child than in the adult, owing to the flaccidity of the abdominal wall. Rachitic subjects, unless there be much distention of the intestines by gas, are particularly favorable, and the spleen usually enlarged and the liver prominently projecting from beneath the border of the ribs are readily felt. Indeed, I have at times been able to palpate the kidneys with comparative ease.

Auscultation will be the next step in order, for it is wise to leave percussion to the last, for fear of alarming the child and thus rendering further progress in the examination an utter impossibility.

The examination of the chest can be most satisfactorily made while the child is asleep, and the phonendoscope is of especial value here. The back furnishes the largest surface for auscultating the lungs and presents to the ear the most important areas for auscultation, that is, the sides and bases. Rarely are the apices involved during childhood, and when so, it is hardly possible to decide with any degree of accuracy upon their condition.

Consolidations are not as readily discovered in children as in adults, owing to the resiliency of the chest-wall and the com-

parative fineness of the bronchi and the immature state of the air-vessels. Consequently, in a pneumonic process the signs of occlusion of a bronchus are more liable to be discovered than typical dulness and bronchial breathing. If the child be awake it should be laid across the nurse's shoulder with the back to the examiner, so that the ear can be applied directly over the posterior chest. Should it begin to cry we must avail ourselves of this opportunity to determine broncophony, or total absence of function in a particular area.

The murmurs of congenital heart affections are, as a rule, best heard posteriorly in the interscapular space, and when such an affection is suspected the heart must be examined from the back as well as directly over the heart anteriorly.

Much could be said regarding the pulse, temperature and respiration; but here it must suffice to emphasize the importance, when studying these physical signs, not to confine ourselves to them individually, but consider them collectively, and note in particular the deviations from the normal relationship existing between them. A single example will suffice to explain. We know that in the early stages of typhoid fever there is a rapid and progressive rise in the temperature, while the pulse-rate is but slightly increased, not conforming to the usual increase of pulse-rate accompanying an increase of body temperature. Likewise, in pneumonia, the ratio of the pulse to the respirations, which normally stands about four to one, may become two to one, especially when there is dyspnoea.

From this meagre *résumé* of that rich field, the physical investigation of diseases as found in children, the all-important fact is to be gleaned that the closest observation and the most accurate discrimination of all the signs which indicate an aberration from the normal standard of health are the first essential steps to an understanding of these diseases. And after we have learned to fully understand them, and can recognize them at a glance, then the subject of diagnosis will stand before us unveiled of its mystery, and no longer the silent, enigmatical Sphinx.

A RESUME OF THE THERAPEUTIC EFFECTS OF PULSATILLA.

(A discussion upon that subject before the A. R. Thomas Club of Philadelphia, Pa.)

BY JAS. C STIRK, M.D., AND H. I. JESSUP, M.D.

To obtain the best results from pulsatilla, it is of the utmost importance to use a tincture made from the green plant of the European variety—the *pulsatilla pratensis*. Dried plant tinctures and those made from the American herb are very unreliable, and differ decidedly in their drug action. The use of this remedy is almost entirely confined to the Homœopathic school, and it is of pronounced value in the treatment of a great variety of diseases. It is unnecessary to give you a description of the typical pulsatilla patient,—with her you are all more or less familiar,—but I will endeavor to point out a few of its characteristic symptoms upon which to base your prescription. First we should realize that the drug acts primarily on the venous circulation—that is, the right heart, veins and capillaries—and from this we can readily understand its value in the treatment of diseased conditions dependent upon obstruction to this portion of the vascular system. Its action on all mucous membranes is quite characteristic, here producing a catarrhal inflammation with a bland yellow or yellowish-green discharge. In acute, subacute and chronic nasal catarrh, with or without loss of taste and smell, and in subacute and chronic bronchitis with profuse discharge and expectoration of mucus, also in acute and subacute inflammations of the middle ear and of the external auditory canal with intense pain, swelling and redness, this remedy is very efficient. Acute or chronic dyspepsia characterized by gastric catarrh or subacute gastritis and frequently dependent upon fatty foods, pastries, or a rich mixed diet, and associated with a white or yellowish-white coated tongue, nausea, vomiting, anorexia, sick headache and heartburn, frequently finds its relief and cure by the use of pulsatilla. It does good service also in intestinal catarrhs, with a mucous diarrhœa, where the stools are changeable in character and worse after midnight. But it is in diseases of women that

we use this drug most frequently. Here it is of marked value in correcting scanty, delayed or vicarious menstruation, especially in young girls at puberty, when the flow is absent or not normally established. In suppression of the menses from fright or chill, in oöphoritis, and in simple mucous leucorrhœa with pains in back and the characteristic nervous symptoms, it has been found an excellent remedy. Dysmenorrhœa has been frequently cured by the use of drop doses of the tincture 3 or 4 times daily. It is also of use in the treatment of subacute and chronic catarrh of the bladder, especially so in pregnant women where there is frequent desire to urinate—the urine being thick and turbid from the admixture of mucus.

Its action is almost specific in acute uncomplicated cases of epididymitis, drop doses of tincture being used every two hours. Orchitis may be controlled and dissipated within a few days by small and frequently repeated doses of the drug. It is often indicated in rheumatism of the small joints, whether inflammatory, gouty or gonorrhœal in origin, and accompanied by sharp, stinging, tearing pains, very erratic in character, and relieved by pressure, motion, and cold, but aggravated by warmth and in the evening.

J. C. S.

As *pulsatilla* exerts such a marked influence on mucous membranes, we might naturally expect to find the conjunctiva affected by this drug. Nor are we disappointed in this expectation, as we find among the many symptoms recorded: (*a*) dimness of vision, like mist before the eyes, relieved by rubbing or wiping the eyes; (*b*) inner canthus agglut. in A. M.; (*c*) pressing burning pain in eyes, like sand in eyes; (*d*) discharge from eyes from thin mucous in character to thick yellow purulent. All of these symptoms point unmistakably to a *catarrhal* inflammation (at least) of the conjunctiva, and we find this remedy the sheet-anchor in all such cases. It has even been of service in cases of ophthalmia neonatorum of the milder type.

We find in the symptomatology of *pulsatilla* frequent mention of styes. Here again we have the effect of this remedy upon the mucous membrane evidenced. The inflammation of the conjunctiva causes a thickening of the lid edges. This thickening of the lid edges, and the discharge which accumulates

on the edges of the lids and favors the development of germs, contribute the necessary factors to produce occlusion of the mouths of the sebaceous glands and supply the necessary germs to cause inflammation in these glands—in short, to produce styes.

Still further we find such symptoms as the following: (*a*) sensitiveness to light; (*b*) lachrymation; (*c*) ulcers on the cornea. This is a word-picture of those cases of ulcers of the cornea which so frequently accompany *catarrhal* inflammation of the conjunctiva and air-passages.

Weeping eyes (in wind): we find pulsatilla of great use in the early stages of dacryocystitis, if dependent upon a stricture of the nasal duct produced by a *catarrhal* inflammation of the nose.

Among the more prominent symptoms of pulsatilla we find mention made of pustule on the conjunctiva and cornea. Thus we find the remedy of great service in phlyctenular inflammation of the conjunctiva and cornea, especially if the patient is of a mild, yielding disposition and sandy complexion, and if there is stomacheic derangement. The action of pulsatilla is not quite as clear in the production of this phlyctenular condition. It is probable, however, that it is through its action upon the stomach.

The symptoms of flashes of fire and sparks before the eyes would suggest the use of pulsatilla in at least some cases of irritation or inflammation of the retina. This remedy has been used with success, it is claimed, for those cases of amblyopia which are dependent upon the suppression of any bloody discharge, and particularly the menses. I have never had a chance to try its action in such a case.

H. I. J.

TREATMENT OF ENLARGED LYMPHATICS.—At the November meeting of the Liverpool Branch British Homœopathic Society, Dr. Simpson, speaking upon the subject of enlarged glands, strongly affirmed his faith in medicines, giving illustrative cases. He especially recommended:

1. *Calcareo carbonica*, when the strumous diathesis was well marked.
2. *Baryta carbonica*, in non-strumous cases.
3. *Sulphur*, to clear away the chronic indurations which often remain for a considerable time after acute glandular affections.

EDITORIAL.

THE COMPULSORY REGISTRATION OF TUBERCULOSIS AS A CONTAGIOUS DISEASE.

THE question of the compulsory registration of tuberculosis as a contagious disease is again being agitated. Were the benefits to the community as sure to result as the advocates of the measure seem to think, there would not be found so many physicians still opposed to its enforcement. Its advocacy, on the other hand, by so many of exceptional experience in the treatment of the disease proves that it must possess some merit. It becomes, therefore, the duty of every physician carefully to consider the question and to decide whether compulsory registration is the sole means of accomplishing the results desired by all, viz., the limiting and final stamping out of the fell disease.

In deciding the question, however, we must remember that, while seeking ultimately the good of the community at large, the rights of the individual must be respected. These dare not be infringed unless it can be proved, without cavil or doubt, that only by so doing can the community be benefited. Not everything which is desirable is advisable, nor are legislation and compulsion usually the only, or even the best, means of accomplishing beneficial reforms.

Before advocating this measure, therefore, we must be convinced that it is the sole and best means at hand to limit the spread and reduce the mortality rate of tuberculosis, and that it can be carried out without encroaching upon the individual rights of the patient or of the physician. The danger of gradually developing a system of State Medicine, which will eventually become but a cog in the wheel of the great political machine, is not an imaginary one, as we pointed out and demonstrated some time ago. The reporting to a Board of Health all cases of tuberculosis would be in itself a very simple and apparently harmless procedure, but the subsequent action on

the part of that Board might readily be of a character to constitute a very serious infringement of the rights of both patient and physician. It behooves us, therefore, to go slowly.

Let us briefly examine the arguments by which the desirability and necessity of compulsory registration of tuberculosis as a contagious disease are sought to be established. Those usually advanced may be concisely stated as follows:

Tuberculosis having been proved to be not an hereditary, but a contagious, disease, it should be subjected to the same laws and restrictions as are other contagions—the more so, indeed, by reason of its far greater mortality. We often hear it said that because it is capable of being communicated, it is therefore preventible, and therefore it should be prevented.

Decided reductions in the death-rate from tuberculosis have been noted, and these can only be ascribed to the partial or complete carrying out of the principle of compulsory registration and the attendant measures for the limitation of the spread of the disease by disinfection.

That compulsory registration of all cases by the attending physician is the necessary first step towards the improvement of the sanitary conditions surrounding especially the consumptive poor during their lives, and the thorough disinfection after their deaths of the localities infected by them.

These, elaborated and enlarged, include all the arguments we have ever seen advanced in favor of the measure. Let us examine them *seriatim*.

1. While the earlier view in regard to the hereditary character of tuberculosis has received necessary modifications since the discoveries of Koch and his followers, and the fateful inheritance has been limited to an inheritance of a predisposition merely, yet the possibility of direct placental infection has been demonstrated by its occurrence in the lower animals, and by the development of the disease in different members of the same family, though early separated, and reared under entirely dissimilar conditions and in the most varied environments. In hereditary syphilis and its late manifestations we have a striking parallel. Tuberculosis is, therefore, a contagious disease only to a limited degree, and the results of disinfection, no matter how thoroughly and persistently applied, must for a long time to come be also limited. We cannot, therefore,

delude ourselves with the hope of a speedy stamping out of the disease, and should not allow our judgment as to the means to be employed be biased by any unfounded enthusiasm.

Furthermore, would not the argument applied to tuberculosis be equally applicable to syphilis and gonorrhœa? We need no reminder of the terrible ravages of these diseases, which are also, according to the argument, capable of being prevented and eradicated by means of compulsory registration. Those of us who have seen or have read of the near and remote effects of these diseases, "unto the third and fourth generations," should be equally insistent upon their compulsory registration. Any interference with rights, or inconvenience, or even distress, would surely be more justifiable in such cases than in the case of the innocent tuberculous. The argument that because a disease is communicable it is therefore preventible, and therefore must be prevented, proves too much, or at least more than public opinion, even among physicians, is willing to accept—just at present.

2. That there has been a reduction of the death-rate from tuberculosis in some localities is proved by statistics, and that some of this reduction may justly be attributed to the dissemination of a better knowledge of the hygienic treatment of the disease by volunteer effort, or in connection with compulsory registration, no one will deny. There are, however, several other factors in this reduction of the death-rate which must not be lost sight of in estimating the value of the measure proposed. The general plane of living in most communities is higher than it was a decade ago, and consequently, as figures show, the general healthfulness has improved, and with it also the tendency to tubercular disease has been lessened. Again, the climatic treatment of consumption has been so prominent a feature at the present time that no inconsiderable amount of the reduction can be explained by the removal of patients in the last stage of the disease from the cities to other localities only to have their deaths recorded there instead of at home. That these poor innocent falsifiers of statistics are numerous, appears from the complaints constantly meeting us in the journals from physicians practicing in health resorts. Their voices are continually raised against what they regard as the too frequent practice of sending patients away from home merely to die.

Again, if the many boasted cures for tuberculosis with which the country is flooded have had nothing to do with the reduction of the death-rate, then is the practice of medicine indeed a delusion and a snare.

We cannot, therefore, regard an argument based upon a reduction of the death-rate coincident with the introduction of the measure advocated as at all conclusive as to the value of such measure.

3. Finally, granting that some of the reduction in the death-rate may justly be set down to the credit of the measures to follow upon compulsory registration, the fact that such reduction has taken place where there has been no compulsory registration (*e.g.*, here in Philadelphia) proves that this latter is no absolute necessity for the accomplishment of the good desired. Much has been done by individuals and by societies composed of those particularly interested in this subject, and we cannot but feel that it is a mistake for them to appeal to legislation to compel unwilling converts to their mode of thinking. They constantly disavow any intention of interfering with the status of the attending physician in the eyes of his patient, and yet the registration is in all cases to be followed by the intervention of a representative of the Board of Health, who shall be authorized to do what the physician could do himself, or have done, or of his own motion call upon the Board to do. The case while not actually taken out of his hands, becomes virtually a protégé of the Board, which, with leaflets and pamphlets of instructions, and disinfectants, follows him up from place to place while living, and finally, when dead and no longer able to work harm, scrapes the walls of his last dwelling-place. All these things can be and are being done without calling in the aid of outside officials, and in spite of the fact that there is no compulsory registration. We therefore conclude that this latter is not absolutely necessary, and that, while in itself considered, it may be perfectly harmless, it demands in addition subsequent measures which render it not even desirable.

We have said nothing about the effect upon the patient of the registration and the subsequent visits of the inspectors and their acts. The effect could not but be depressing and prejudicial. The attending physician could do all that is necessary and in a way that would be least objectionable to his patient.

At any rate, until sufficient hospital accommodation for the consumptive poor is provided by the State, all outside interference, setting up unattainable requirements, can only be regarded as a cruel mockery. Let all physicians be enlightened as to the benefits sought to be gained by compulsory registration, let their sympathy in these ends be won, and they will voluntarily work for their accomplishment without the necessity for legal compulsion. We have all no doubt experienced the inconvenience, to use no stronger term, resulting from the compulsory registration of other contagious diseases, and the subsequent measures adopted by the Board of Health, and we would be loth to open the door to any new possibilities by advocating the compulsory registration of tuberculosis as a contagious disease.

THE PHILADELPHIA MEDICAL JOURNAL AND DR. GOULD.

THREE years ago the *Philadelphia Medical Journal* was born, Dr. George M. Gould being its editor. As the result of considerable energy on the part of its editorial and business management, and the investment of thirty thousand dollars by its projectors, it secured a large patronage among physicians and advertisers. But it has come to grief; with all its numerous following, the journal did not make money; on the contrary lost it, for it is currently stated that the thirty thousand dollars of capital has vanished in meeting expenses. The trustees have seen fit to attach the blame for this state of affairs to Dr. Gould, so it is said, and he has been summarily deposed from the editorship without as much as an opportunity to bid farewell to his readers.

During the early years of Dr. Gould's editorial work we saw fit to criticize his course most severely, because of the bigoted attitude assumed by him towards homœopathy and its practitioners. Of our record in this respect we are well satisfied. We believe it did good, for while in his conduct of the *Philadelphia Medical Journal* he showed that his love for homœopathy had not increased, he nevertheless tempered his criticisms in great measure.

Notwithstanding Dr. Gould's record towards homœopathy, the American spirit of fair play leads us to say that during his

editorship of the *Philadelphia Medical Journal* he did good work. His magazine was always entertaining or instructive,—sometimes both, but never neither. But the *Journal* did not make money; worse than that, it lost thirty thousand dollars. To any one acquainted with the expenses attendant upon the production of a magazine, the reason for this is not hard to see. Printing and paper cost something, and the *Journal* gave so much for its subscription price that each new subscriber, instead of being a source of income, became a liability.

Dr. Gould has been downed; but already he announces that he will not stay down, for notices have been sent to numerous physicians requesting their co-operation in starting a new journal, of which Dr. Gould shall be the editor. *Mirabile dictu*, even the despised homœopaths have been invited to deposit their ill-gotten gains—blood-money—money made out of homœopathic practice—in the treasury of the new publishing venture. Three years ago Dr. Gould would have reminded the maker of such a proposition of the old adage that the receiver is as bad as the thief. But times have changed, and with them Dr. Gould.

The attempt to secure homœopathic co-operation does not end here. As editors of the HAHNEMANNIAN MONTHLY we have been the recipients of a most courteous communication, inviting us to call the attention of our readers to the financial scheme for floating a new medical journal under allopathic influences, adding, furthermore, that such editorial notice will doubtless please our readers.* We could not understand this letter. What was wrong with us? Could we see? Could we remember? We did not know, and we wrote for an explanation as to the attitude of the new journal towards the members of the homœopathic school. We received no reply. We had written to the same old Dr. Gould.

At least we thought he was the same; but then we learned that a prominent homœopathic physician had been invited to permit the use of his name as a collaborator of the new journal. And then we thought that Dr. Gould was about to assume a new rôle. He was about to become a peacemaker; the lion and the lamb were to be made to lie down together, and he was

* Here it is.

the self-appointed little child to lead them until such time as the lion should destroy the lamb,—by benevolent assimilation, so to speak. And here the matter rests for the present.

THE OPERATIVE TREATMENT OF CIRRHOTIC ASCITES.

HITHERTO cases of hepatic cirrhosis, with consequent ascites, which would not yield to internal medication and frequent tapings—and these, to say the least, constitute the majority—have been looked upon as hopeless. During the past decade a number of attempts have been made to increase the normally existing collateral circulation between the caval and portal systems.

According to Dr. Northrop these anastomoses take place between the superior and middle and inferior hæmorrhoidal; between the gastric or coronary and the œsophageal; between the lumbar veins and the epigastric and internal mammary, finally reaching the superior vena cava through the azygos veins; between the veins draining the capsule of Glisson and the phrenic.

Nearly a score of operations have been performed to accomplish this end, by producing adhesions between the parietal peritoneum and the omentum, between the diaphragm and the liver and spleen, or between the latter and the abdominal wall. While such an increased anastomosis may sidetrack the results of portal obstruction, experiments have shown that a too sudden entrance of this blood into the general circulation is followed by a dangerous auto-intoxication. Thus, a free communication between the *venæ porta* and *cava* produce nervous symptoms or even fatalities, while an intervening capillary circulation, such as is brought about by these operative measures, will prevent these phenomena, or at least diminish them, for they were observed in one of the operative cases which recovered.

An interesting and very unusual case which illustrates the evolution of the plan is one of Talma's; a nine-year-old boy suffering from an acute parenchymatous nephritis, together with hepatic and splenic enlargement of unknown origin. With the subsidence of the nephritis the anasarca disappeared, but the ascites recurred after repeated tapings. On abdominal section the peritoneum was found normal, and at a second op-

eration the omentum was fastened to the wound, completely curing the ascites. The spleen remaining enlarged, it was implanted between the peritoneum and the parietal muscles, the ultimate result being a diminution in the size of both spleen and liver, and a complete restoration to health. In another patient who died some time after operation, the omentum, liver and spleen were found to be attached to the adjacent peritoneum by firm fibrous adhesions, in which venous channels were readily demonstrable.

The operative prognosis must necessarily be grave in the natural order of things, such cases being, as already stated, hitherto hopeless, and usually complicated by cardiac or renal disease. Hence local anæsthesia has been tried, but as the parietal peritoneum is notably more sensitive than the visceral, a general anæsthetic has had to be substituted. In all probability subarachnoid spinal anæsthesia will find a useful sphere in these cases, as the method is at least applicable to all sub-diaphragmatic work. It has been claimed that while kidney and heart lesions may contra-indicate one or another anæsthetic, functional activity of the liver cells is essential to success in this procedure.

The operative technique consists of the medial or lateral supra-umbilical incision; scarification of the adjacent surfaces of the liver and spleen and of the diaphragm or parietal peritoneum, together with a portion of the latter on either side of the wound; this may be done with a blunt curette, the point of a scalpel, or by gauze mops which induce less oozing; any ascitic fluid is evacuated and the omentum is sutured to the wound, as well as to the adjoining scarified peritoneum, after which the abdomen is closed. The recurrence of the ascites during the establishment of the collateral circulation has been variously treated, either by providing suprapubic drainage, which, of course, has its drawbacks in the consequent obstructing adhesions and the possibility of infection, or by tapping the fluid accumulations as they appear in diminishing amounts.

In spite of the limited number of reported and personal cases, this operation seems to offer a last, even if a somewhat dangerous, chance for a class of cases hitherto consigned to palliation or to death.

NIAGARA FALLS VS. ELSEWHERE.

AT the Thursday morning session of the Washington meeting of the American Institute of Homœopathy, with over two hundred members present, it was voted by a large majority to hold our next annual meeting at Niagara Falls, N. Y. On Saturday morning, with but twenty-seven members present, within one hour of the time of adjournment, a resolution was railroaded without debate, this latter resolution bidding fair to do just what the majority of members in attendance at the meeting did not want. This second resolution, apparently innocent on its face, provided that if the executive committee could not get suitable hotel accommodations for the Institute at Niagara they should be empowered to change the place of meeting.

On the first day of January the President of the American Institute of Homœopathy sent out his greeting to the members, the secretary of the association uniting with him in signing the document. In no place did this greeting mention the place of meeting, but left the members in doubt.

To insure good accommodations at Niagara Falls the local committee of arrangements secured an option on quarters sufficient for the royal entertainment of the Institute, which option expired on January 1st, the executive committee not having taken action.

So much for the facts.

But there is a rumor.

Rumor says that it is contemplated by the executive committee to change the place of meeting to some other location, probably to Cambridge Springs, Pa. This is a place of which we never heard until we saw its advertisement in one of our contemporaries. We understand that there is but one hotel there, although it is reputed to be commodious.

There are two reasons why we believe that the Institute should meet at the place selected by its members at the Thursday session: (1) Because the taking of it elsewhere by the executive committee is revolutionary, unless such a course on their part is prompted by good reasons and unselfish motives. (2) Niagara Falls is by all odds the best place for the Institute's interests.

The hotel accommodations are unlimited, because of the many large and small hotels in that little city. Knowing this fact, the proprietors of the hotel selected as headquarters will not dare to give poor accommodations, as those who are dissatisfied can readily go elsewhere. It has been the rule, when the Institute met at a place with but few hotels, that the members were obliged to put up with hotel tyranny or go home. At Waukesha it was facetiously observed that the "waiters were the autocrats, and the doctors were the waiters." But that did not make the doctors anything but poor suppliants for attention in the dining-rooms.

The attractions of Niagara will of themselves draw a large attendance.

This year Niagara will be unusually attractive, because the Pan-American Exposition will be held in its suburban town—Buffalo. Those who are in a position to know say that this Exposition will exceed in enterprise and beauty the Chicago World's Fair. This will serve still further to add to the attendance.

By reason of the Pan-American Exposition, railroad fare will be low to Buffalo, and therefore to Niagara Falls. This will be an inducement to many, who have not too much money to spend in railroad fares.

Inasmuch as there are so many attractions to take visitors to Niagara, the attendance being larger, there will be a greater number of new members admitted than at any time in the previous history of the Institute.

It is objected to Niagara that the local attractions and the Exposition in Buffalo will keep members from attending the sessions. To this we reply that if the essayists and debaters do not make themselves sufficiently interesting, they alone will be to blame for it. No complaint was made at Chicago concerning neglect of the Institute in favor of the World's Fair. None will be made at Niagara.

We are informed that Niagara Falls is the convention city of 1901. Already numerous associations have made the necessary arrangements for the accommodation of its members. If our executive committee delay much longer they will find that the condition for which the Saturday resolution provided, "inadequate hotel accommodations," has become a fact, and they

will find it necessary to take the Institute elsewhere. If such a course is made necessary, they, and they alone, will be to blame for it. At this time of writing, we believe that it is not too late to retrieve the mistake that has been made.

In justice to the President, we will state that he is reputed to have announced that, as a member of the executive committee, he will not favor a reversal of the majority vote of the Institute.

THE PURULENT RHINITIS OF CHILDREN AS A SOURCE OF INFECTION IN CERVICAL ADENITIS.—Cobb, of Boston, narrates the history of a child without any previous trouble with the nose or throat who had diphtheria at the age of two years, and following it a purulent discharge from the nose; two years later enlarged tonsils and adenoids were removed, and one year later she still had a purulent discharge from the nose, together with a cervical adenitis following an acute coryza.

Every case of adenitis is the result of infection. The physician to-day looks for the source of infection in each case in which he finds enlarged glands, assuming the adenitis to be only a symptom, except when it occurs in the neck. When we come to consider the sources of infection in cervical adenitis, we are met with the belief that these cases are practically all tuberculous. There is, however, no evidence that even a considerable proportion of these cases is due to tubercular infection. The latter must occur either as a general systemic infection, in which case we should find manifestations of the disease in other parts of the body, or as a local infection from the parts immediately surrounding the neck, where we should find the original lesion or the scar tissue resulting therefrom. No such evidence is discoverable in most cases.

In this case a purulent rhinitis was a direct sequel of an attack of diphtheria. A chronic nasal discharge, with a few exceptions due to foreign bodies, syphilis or tuberculosis, always has its sources in the nasal accessory sinuses. A true diphtheritic membrane may be formed in the accessory sinuses during the attack, or the latter may become intensely inflamed as a result of secondary infection by other bacteria. This is the relation of the diphtheritic attack to the subsequent purulent discharge in the patient under discussion; but in other cases it may be acute coryza, influenza, croupous pneumonia, scarlet fever, measles, facial erysipelas, typhoid fever, cerebro-spinal meningitis, foreign bodies in the nose, etc.—in fact, any way in which infection may reach the sinuses. Infection having taken place and the discharge once established, absorption will occur sooner or later; and since the lymphatics of the nose are directly connected with those of the neck, a cervical adenitis may result at any time. As long as the source of infection remains unhealed it is hardly reasonable to hope to cure the adenitis. The infected glands can be removed, but this does not prevent others from becoming involved. It would seem more in line with modern surgical teaching to first find the source of infection and to make the healing of this the objective point of treatment.—*Boston Med. and Surg. Journ.*, Jan. 10, 1901.

GLEANINGS.

ACUTE DILATATION OF THE HEART IN DIPHTHERIA, INFLUENZA, AND RHEUMATIC FEVER.—Lees, referring to the many sudden deaths occurring during and after diphtheria, asserts that the action of the heart is maintained by the automatic contractions of the cardiac muscle, and it is by no means certain that a neuritis of the vagus would arrest the working of that organ. It seems likely, therefore, that the fatal syncope which may follow diphtheria is due to disease of the muscular wall of the heart itself, rather than to disease of the nerves which pass to it. Moreover, the observations of a number of investigators show that in fatal cases of diphtheria the cardiac muscle is often much degenerated; and the conclusion is irresistible that it must be more or less degenerated in many cases that recover. The clinical detection of this degeneration becomes, therefore, of extreme importance, for cardiac syncope may be avoided and many lives saved.

The clinical indications which should be sought for are these:

1. Feebleness of the pulse wave.
2. Feebleness and diffusion of the cardiac impulse.
3. Extension of the cardiac dulness to the left.
4. Feebleness of the first sound at the apex, with accentuation of the pulmonary second sound.
5. Marked accentuation of the aortic second sound.

All these physical signs need careful and accurate investigation. Auscultation must be supplemented by palpation and percussion, and especially must the latter be used to determine the "deep" cardiac dulness, which alone affords certain evidence of the size of the heart. In diphtheria, so long as the cardiac dulness extends not more than one finger-breadth beyond the nipple line, there is usually no immediate danger; but if the dulness is greater than this, the case should be watched very carefully. If the dulness extends two finger-breadths to the left of the nipple line, there is urgent peril, and the child must not be allowed to sit up in bed for any reason whatsoever. Similar conditions often accompany and may follow influenza. In rheumatic fever, even in the most subacute attacks, acute dilatation of the heart is invariably present; but it is a very remarkable fact that in the latter case it is much less dangerous than in diphtheria or influenza. It must be due to the different effects of the several toxins upon the cardiac muscle.

In any case, sudden vomiting is often the danger-signal. Pallor, coldness, and general feebleness follow, and the cardiac dulness is found to have increased by an additional finger-breadth within a few days or even within a few hours.—*Brit. Med. Journ.*, Jan. 5, 1901.

F. Mortimer Lawrence, M.D.

IMMUNIZATION TO HAY FEVER.—Two years ago Dr. Holbrook Curtis reported to the Laryngological Section of the New York Academy of Medicine

the results of some experiments upon a patient who had suffered from childhood with violent attacks of hay fever with spasmodic asthma. These paroxysms were brought about by any exposure to the perfume of flowers; she was so susceptible that to pass a florist's shop in the street provoked an attack. Curtis determined to try the immunizing effect of giving internally the watery extract of certain flowers and their pollen. For two weeks he gave the sterilized infusion of roses, and at the end of that time the patient could tolerate that flower in her bedroom. The violet and lily-of-the-valley were tried with equal success; and then it was found that other flowers could be added to the bouquet always kept at her bedside. There has been no recurrence of the paroxysms.

It is a strange fact that not only is immunity from attack thus secured, but after a paroxysm is established and has reached its height, it is at once lessened and often controlled by the causative drug. Experience having demonstrated the latter fact, last summer Curtis obtained the services of a botanist to secure enough ragweed to make an experiment upon hay fever sufferers on a large scale this year. The drugs were delivered too late for a preventive treatment to be carried out last season; but in some eight or ten patients on whom the method was tried at the commencement of the attack, even up to two weeks' continuance of the disease, the results were remarkable.—*Med. News*, July 7, 1900.

F. Mortimer Lawrence, M.D.

RELATIVE VALUE OF ALBUMOSE AND ALBUMIN.—Dr. Paul Cornet, of Paris, in *Le Progrès Médical*, in speaking of the comparative value of albumose (artificial) and albumin, claims that in no case is the artificial albumose superior to albumin, if it is equal to it, because the nitrogenous substance of a gramme of albumose is absolutely the same as that of a gramme of albumin, with an identical caloric value. Further, the albumin taken into the stomach is taken up as albumin by the organism. This is by no means proven to be the case with the artificial albumoses and peptones, and the nitrogenous products which arise from their decomposition (leucin, tyrosin, asparaginic acid) would not be replaced by albumin. The nutritive value of an aliment is measured by its utilization by the organism. The less an aliment is absorbed the greater is its inferiority to another aliment of the same caloric capacity, but better absorbed. Referring to the experiences of Ellinger bearing upon powdered meats and somatose, he claims that the powdered meat is ten times better absorbed than somatose (albumose), or, more exactly, leaves ten times less intestinal residue. The same researches upon animals have been made upon men by Hildebrand and Bomstein, and agree that albumose ingested is for the most part evacuated by the intestines.

He claims also, with F. Vait, that albumose can only be given in small quantities; not over 20 grammes a day, and even in this quantity it frequently becomes irritative to the digestive organs. Also that it can at that be tolerated but a short time, for after a few weeks is developed a repugnance, and even vomiting.

He concludes: 1. That the artificial albumoses have not a nutrient value for the reasons that they are poorly absorbed, and that they cannot be given in sufficient quantity.

2. That the artificial albumoses have an irritating effect upon the intestinal

canal, which effects can under certain circumstances and in a certain measure legitimize their use not only as foods, but as laxatives.

3. That the nutrient qualities of powdered meats are far superior to those of albumose.

John J. Tuller, M.D.

IDIOCY.—Dr. Bourneville, before the Section on Psychiatry of the 13th International Congress of Medicine, meeting at Paris during the past summer, classified the idiocies from the standpoint of pathological anatomy as: 1. Symptomatic idiocy from chronic meningitis. 2. Symptomatic idiocy from chronic meningo-encephalitis. 3. Symptomatic idiocy from an arrest of development of the convolutions without malformation, with lesions of the nerve-cells (congenital idiopathic idiocy). 4. Symptomatic idiocy from hypertrophic sclerosis. 5. Symptomatic idiocy from atrophic sclerosis (a hemispheric or bi-hemispheric sclerosis; b, lobar sclerosis; c, sclerosis of isolated convolutions). 6. Hemiplegic or diplegic idiocy from lesions in the medulla due to a vascular obliteration or to hæmorrhage. 7. Symptomatic idiocy from simple or complicated ventricular or extra-ventricular hydrocephalus (hydrocephalic idiocy). 8. Idiocy with pachydermic cachexia or myxœdematous idiocy associated with the absence of the thyroid gland. 9. Symptomatic idiocy from an arrest of cerebral development with congenital malformations. 10. Symptomatic idiocy of microcephalus from an arrest of development with or without malformation or any known cause of lesions appearing after birth.

The author has even observed a case of idiocy in which lesions of the bones could be asserted the exclusive cause, and particularly the premature closing of the bones of the skull.—*Progrès Médical*.

John J. Tuller, M.D.

CATARACT ABSORBERS.—Many years ago there was a good deal of newspaper gossip of the pseudo-scientific sort as to the absorption of cataracts by drugs used internally or applied locally. The ophthalmologists soon silenced the nonsense until of late, when it seems to have been galvanized into life by much the same class of people who were interested in it formerly.

We have heard something of institutions exploiting such remedies and making extravagant claims for their powers. When newspapers publish the reports of cases of cataract or advertisements claiming to cure, they perhaps have no conception of the suffering and waste of money they cause. There is, indeed, a class of so called physicians who, either through deplorable ignorance or more deplorable shamelessness, delude patients with the silly hopes that drugs and applications can "dissolve" or absorb cataract. We believe that cataract may be prevented, and its progress sometimes retarded or even brought to a standstill, by the relief of eye-strain. But to humbug patients with the false belief that an existing cataractous lens can again be made transparent by drugs is wanton cruelty and downright quackery.—*Philadelphia Medical Journal*, November 24, 1900.

William Spencer, M.D.

AN EXPERIMENTAL STUDY OF THE ACTION OF ESERIN UPON THE CIRCULATION OF THE EYE.—The property of eserine of lowering intra-ocular tension in glaucoma is well known, though how this phenomenon is brought about is somewhat of a mystery, and the same may be said of the effect of eserine

upon the normal eye. The author has given us a long and exhaustive study of the subject, and has even taken up the histological aspect of the question. He discusses the "iris theory," the "blood-vessel theory," and lastly the theory which attributes the lowering of intra-ocular tension to the effect of eserin in producing a stretching of the uvea, "Die uvealo-pannungs theorie."

His experiments were made for the most part on rabbits and cats. His conclusion as to the effect of eserin upon the glaucomatous eye are as follows: The effect of eserin upon the normal eye is to lower intra-ocular tension. A transient elevation of tension precedes the lowering of tension, and this is to be attributed to a hyperæmia caused by the irritative action of the eserin. This lowering of tension is explained by the fact that the quantity of blood in the eye is lessened and the secretion diminished. The lessening of the quantity of blood in the eye is due to the contraction of the intra-ocular blood-vessels. The filtration capacity of the eye is not primarily changed by the eserin.

The contraction of the pupil does not stand in any causal connection with the lowering of intra-ocular tension. The contraction of the ciliary muscle and the stretching of the choroid produce no change in either the filtration capacity of the eye or in the tension of the eye.

In those cases of glaucoma where the iris is pressed forward, eserin acts by lessening the quantity of blood and the secretion, and in consequence the iris and lens draw back from the cornea, and thus the filtration channels are opened.

The effect of eserin upon filtration is not a direct effect, but an indirect one.—V. Gonholm, Finland (*Archiv für Ophthalmologie*).

William Spencer, M.D.

PERFORATION IN TYPHOID FEVER.—Osler comments upon the gratifying percentage of recoveries as the result of operative interference in these formerly hopeless cases. It is a wonder that perforation does not occur more frequently when we consider the extent and character of the necrotic processes. As the lower eighteen inches of the ileum are chiefly involved, the perforation is usually within this distance of the valve. The higher in the bowel, the more likely is the perforation to be in a small ulcer without much infiltration or necrosis. The position of the terminal loops of the ileum make the first symptoms of perforation hypogastric, and may give to the case a pelvic or an appendicular aspect. A majority of the cases occur early in the third week; the earlier the perforation the greater will be the difficulties in dealing with the bowel. Cases with diarrhœa and with tympanites are more liable to this accident. When we remember that a large proportion of all cases of typhoid fever, if left alone, have no abdominal symptoms—neither diarrhœa, pain nor tympanites—it is not difficult for the attendant to keep his mind constantly on the alert for the danger signals.

Osler has drawn up the following schedule of specific instructions to be followed in cases of typhoid fever in which perforation is suspected:

1. Instructions should be specific and definite to the night superintendent and head-nurses, to notify the house-physician of any complaint of abdominal pain by the patient, of hiccough or vomiting, of a special rise of pulse or respiration, of sweating, or of signs of collapse.

2. House-physicians should note the character of the *pain*. As to (a) *onset*, whether only an aggravation of slight abdominal pain, such as is common, both with constipation and with diarrhœa, or whether it was a sudden, intense pain which caused the patient to call out, and which, though relieved by stupes and ordinary measures, soon recurred in paroxysms and grew worse. (b) *The locality*, whether diffuse or localized in the hypogastric or right iliac regions; radiation, as to penis. It is to be borne in mind that abdominal pain of a severe character may be associated with an acute pleurisy, with distended bladder, with cholecystitis, and with a packed rectum, or may follow an enema.

3. *State of the Abdomen*.—The condition to be noted at once in writing as to the following particulars: (a) Whether flat, scaphoid or distended. Whether, if distended, it is uniform or chiefly hypogastric. (b) Respiratory movements, whether present, if uniform and seen both above and below the navel. (c) Palpation, as to tension and pain, locality and extent, and degree of pressure necessary to elicit; muscle rigidity and spasm, whether present or not, and in which locality, and noting particularly its absence or presence in the hypogastric region and right iliac fossa. (d) Percussion—character of note in front of abdomen and in flanks. Liver-flatness, extent, in middle, nipple, and in mid-axillary lines. Note specifically every third hour. Remember, too, that obliteration may occur in a flat as well as in a distended abdomen. Auscultatory percussion may be helpful. (e) Auscultation—observation of the signs of peristalsis; presence of friction. (f) Examination of the rectum, whether tenderness; fullness between rectum and bladder. (g) Stools—character, frequency, presence of blood or sloughs.

4. *General condition of the patient*: (a) *Facies*, whether change in expression; risus, slight or marked; pallor; sweating, etc. (b) *Pulse*, change in rhythm, rate and force. (c) *Temperature*, whether a drop or not, whether after a tub or not. (d) *Respiration* sudden increase, not infrequent, whether shallow or sighing. (e) *Sweating*, if subject to during attack; if onset with the pain; whether local or diffuse. (f) *Vomiting*, whether with onset of pain or not; character of vomiting. (g) *Hiccough*.

5. *Blood-count*.—Leucocytosis, stationary or rising. May be marked and early. In a majority of cases well followed there is a rise. The constant leucopenia in typhoid fever has to be taken into account. Also a count of the red blood-corpuscles and hæmoglobin, as a decided drop might suggest hæmorrhage.—*Phila. Med. Journ.*, January 19, 1901.

F. Mortimer Lawrence, M.D.

TREATMENT OF INFLAMMATORY DISEASES OF THE UTERUS BY IRRIGATION. —Talley, of Philadelphia, has been practising this method of treatment for acute and chronic gonorrhœal inflammation, metritis and sub-involution of the uterus for a number of years.

The effect of the application of heat and moisture is primarily to cause a vasomotor dilatation and congestion of the part. If the irrigation be persisted in, however, the dilatation of the capillaries gives way to constriction, and the part becomes blanched and shrivelled. He calls attention to this fact in employing this treatment, and warns against the stopping of the irrigation during its primary effect upon the vasomotor nerves, as the patient is then left with a uterus more congested than before. But if the exposure to heat and moisture be continued long enough, the capillaries contract, the uterine tissue becomes blanched, and the patient is relieved of the symptoms incident to the engorgement of her pelvic organs.

The cases amenable to this form of treatment are those in which the cervical canal is patulous and readily admits the passage of the canula.

The apparatus for accomplishing the irrigation of the non-puerperal uterus consists of a narrow canula provided with two wires soldered to its convexity, which allow of the return flow of the irrigating fluid. The canula is perforated at the end and on every side of its distal end. The canula is attached to a fountain syringe or reservoir containing the irrigating fluid, which should be of at least two quarts capacity.

In order that the irrigation may be carried out in ambulatory cases, a special speculum has been provided with a funnel upon its lower valve through which the return flow may pass, by means of a rubber tube, to a vessel under the table. The solution used is water and bicarbonate of soda, one drachm to the quart, and enough carbolic acid to render it mildly antiseptic. The temperature for the beginning should be about 110° F., and this should be increased by gradually adding hot water until the degree of tolerance has been reached.—*American Gynec. and Obst. Journal*, December, 1900.

W. D. Carter, M.D.

DEGENERATIVE DISEASE OF THE SPINAL CORD ASSOCIATED WITH ANEMIA.—Edes, Boston, Mass., says: Which set of symptoms, relative to the above disease, has existed first in any given case cannot always be known, inasmuch as both begin gradually, and neither is likely to be looked for before its presence is distinctly announced. It is more likely to be the nervous ones which first attract attention, as the paresthesiæ or the pareses force themselves upon the attention of the patient. The early sensory symptoms are numbness in the extremities, inability to use the hands for fine work, and a sense of extreme coldness of the feet, which latter, however, may have a double cause in an actual deficiency of circulation as well as interference with paths of sensation in the cord. The motor symptoms are of general weakness of motion and co-ordination, rather than of distinct paralysis of any group of muscles or special movements. The deep reflexes are at first apt to be exaggerated. Later, everything has progressed and we may have a more or less extensive anæsthesia, absolute paralysis, and an absence of deep reflexes.—*Boston Medical and Surgical Journal*, January 3, 1901.

W. D. Carter, M.D.

BACTERIOLOGY OF THE STOMACH.—The gastric contents of several hundred cases were examined to determine:

1. Number of bacteria, spores, or yeast fungi to the c.c. of contents.
2. Presence or absence of gas-forming bacteria.
3. Presence or absence of acid-forming bacteria.
4. Presence or absence of gelatine-liquefying bacteria.

The most important fact learned was the large number of perfectly sterile stomachs, and with the introduction of sterile food the process of digestion was completed perfectly without the formation of bacteria. The number of bacteria per c.c. of gastric contents was so large in some cases that it could be considered an etiological factor in disease. It was also verified that the antiseptic power of the stomach does not depend on the hydrochloric acid alone, for the contents have been found sterile in cases where HCl has been absent and the proportion of combined chlorine low.

Perhaps the most important deduction is the value of fruit eating as a means of sterilization of the stomach. Juices of lemons, oranges, apples, exercise an inhibitory action on micro-organisms, even to the destruction of

such pathogenic organisms as bacillus of typhoid and Asiatic cholera. The administration of fruit-juices is said to be far superior to the too frequent use of lavage.—*Virginia Med. Semi-Monthly*.

William F. Baker, A.M., M.D.

FALSE CARDIAC HYPERTROPHY OF ADOLESCENCE.—Huchard describes a case which he calls a false hypertrophy. The patient was a boy of 16, complaining of palpitation and fatigue. There was loss of weight but no cough. The heart was hypertrophied and no valvular lesion. The condition is explained as follows: That in very many young subjects the chest is poorly shaped, it being long and narrow, with diminution in the transverse and antero-posterior diameters. In these cases it is not that the heart is over-developed, but that the thorax is under size and the heart's movements are hampered. The apex may appear lower and its impulse heavier. These may be accounted for by the lessened intra-thoracic space. This interference in the cardiac action may be followed by changes in the heart itself, and even real hypertrophy may result. The heart is compelled to press heavily against the chest-wall at each systole, and by reason of this over-action it becomes hypertrophied. This condition is not met with in all. The recognition of this condition is of great therapeutic value, as this condition calls for gymnastics to develop the chest, whereas the opposite is required for a true hypertrophy of the heart.—*Journ. de Med.*

William F. Baker, A.M., M.D.

ASTHMA DYSPEPTICUM.—The acute variety is characterized by asthmatic attacks appearing suddenly after meals and attended with dyspnoea and slow pulse. Another variety of this condition is described under the head of *chronic dyspeptic asthma*. This condition is characterized by great shortness of breath on the slightest exertion, not paroxysmal, but continuous; it occurs in patients suffering with gastro-intestinal diseases without any lesion in the heart, lungs or kidney. It yields readily to treatment directed towards the gastro-intestinal condition.

The dyspnoea is brought on by exertion, and is not relieved by belching. In some cases there is a desire for cool air. It is not associated with any one form of stomach derangement. It differs from the acute form in that it is not associated with eating, and the dyspnoea is not relieved by emptying the stomach.—*N. Y. Med. Journal*.

William F. Baker, A.M., M.D.

PREMONITORY STAGE OF POST-SCARLATINAL NEPHRITIS.—*Urinary indications* occur in this order: (a) *Fall* in specific gravity without the appearance of albumin or casts. More or less frequent micturition and irritation of the bladder. Polyuria. (b) *Sudden rise* in specific gravity, no albumin, no anasarca, lessened quantity. (c) Increased output of *urates*, slight fever. (d) A period of *normal urine* then intermits before the onset of the nephritis.—*Pediatrics*, Jan., 1901.

William F. Baker, A.M., M.D.

GNORRHŒAL ULCERATIVE ENDOCARDITIS WITH THE CULTIVATION OF THE GONOCOCCUS.—Notwithstanding the generally believed idea that the gonorrhœal process is limited to the mucous membrane, the fact has been clearly established that gonorrhœa can produce a series of lesions in the body generally, as in the pericardium, joints and peritoneum.

The bacteriological proofs of this have been lacking until recently. A case is reported that, two weeks after the initial attack, was seized with chill, fol-

lowed by fever, delirium, and the symptoms attending an endocardial inflammation soon showed themselves. These continued till death. Post-mortem showed an ulcerated mitral valve. A tough thrombus was found adherent to the margin of the posterior segment of the mitral. Chordæ tendinæ were covered with smaller thrombi.

Microscopically the thrombus consisted of fibrin, red blood-cells and leucocytes. Sections stained with methylene blue and gentian violet showed the presence of the gonococcus. Tube and plate cultures were made from the vegetations on the heart on blood-serum (bullock's) and agar-agar. In one of the blood-serum tubes small gray colonies were observed at the end of 48 hours. Cover-slips showed them to consist of diplococci, which stained readily with gentian violet and were decolorized with Gram's fluid. A suspension of 4 colonies was made in 5 c.c. of broth and injected into 2 young rabbits without any bad effects following. The conclusions reached from these investigations are as follows:

1. Gonorrhœal urethritis may be the starting-point for a fatal septicæmia induced by a pure infection with the gonococci.
 2. Endocarditis and arthritis are occasional complications.
 3. The endocardial inflammation may be started by the gonococcus alone.
- Amer. Jour. Med. Sciences*, Jan., 1901.

William F. Baker, A.M., M.D.

THE TREATMENT OF SUPRA-CONDYLOID FRACTURE OF THE HUMERUS.—Shands (Washington), after pointing out the deformity and ankylosis that so often result from this fracture, suggests the following line of treatment:

"The most important point in the treatment of these cases is an accurate knowledge of the position of the fragments of the broken bone. For obtaining this information, we have in the X-ray all that can be desired, and its aid should be had in every case where the least doubt exists. When the diagnosis is made, the treatment is perfectly plain. The broken ends should be brought into the best possible approximation and held there until union is firm; when it is impossible to obtain a perfect approximation, an incision should be made, exposing the fragments to view, which, when put in the desired relation, the one to the other, should be secured by some extraneous means. There are many conditions that may oppose this end, such as intervening tissue and muscular action, especially when the line of fracture is oblique. My preference is to drill a hole in the fragments and then to suture them in position with kangaroo tendon. When the fracture is oblique, I have found the tendency for the fragments to override each other so great that suturing did not do so well. In these cases I have left the drill in, which is a perfect method of holding the fragments *in situ*. I use a drill that is long enough to project through the dressings, including the plaster-of-paris. The wound is closed, and the drill is removed at the end of the second week; the little wound closes almost at once."

The author reports three cases treated by this method. The fractures occurred in children, from three to seven years of age, and in all of them the results as to symmetry and function were uniformly satisfactory. Skiagraphs are given showing the fracture, after its reduction, supposedly, and the improvement in the position of the bones following the use of the drill and suture.—*New York Medical Journal*, December, 1900.

Gustave A. Van Lennep, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CARDUUS MARIANUS IN GALL-STONE COLIC.—Dr. Bourzutschky speaks enthusiastically of the virtues of *carduus marianus* in cholelithiasis. His first case was a woman of thirty-three years, who for a year had suffered from attacks of gall-stone colic, which had appeared regularly two or three times a week without interruption; at the same time there were whitish diarrhœic stools. A season at Carlsbad, with subsequent use of the salts, had been without result. *Carduus marianus*, four drops three times a day, was prescribed, with a meagre diet and exercise in the open air. Peculiarly enough, from the very first day the seizures ceased, and though her general condition the first few days was extremely bad, there were no local symptoms. The remedy was continued for three months as a preventive, and no return of the pain was noted. She increased fourteen pounds in weight and her periods returned. She then became pregnant, and after it had been discontinued for three weeks she had a recurrence—three attacks. The drug was taken again for six weeks, with complete disappearance of the colicky attacks.

He states that in the tincture this remedy has been of great value to him in gall-stone colic, in treating the fundamental condition. In one case the gall-bladder was so dilated that it was to be palpated as a pear-shaped body two fingers' breadth below the navel. Here also the colic quickly vanished on the third day after beginning to take the remedy, and even then after overeating. The patient recovered and was restored visibly to health, and has remained so without any change being noticeable in the state of the gall-bladder. From his observations he thinks the remedy to act better in females than in males. *Homœopathische Monatsblätter*, No. 9, 1900.

Frank H. Pritchard, M.D.

THE TREATMENT OF NASAL CATARRH.—During a discussion upon the treatment of nasal catarrh at a recent meeting of the A. R. Thomas Club, Dr. Edward R. Snader, of Philadelphia, said that in the ordinary forms of nasal catarrhs, the acute rhinites, it was exceptional for him to resort to any local treatment, and then only within the first twenty-four hours after their inception. His favorite medicines for the first stage of an acute cold in the head are aconite, belladonna, gelsemium, camphor, *alium cepa*, *ferrum phosphoricum* and *penthorum*. This latter remedy he has used with satisfaction in a few cases. He prefers the *ferrum phos.*, and said that this medicine was in the possession of numbers of his patients, who used it successfully to break up a "cold" in its incipency. He has great confidence in its ability to do this, and seldom needed the gelsemium, which had seemed efficacious in those cases which did not yield promptly to the first mentioned remedy. He prescribed bell. where the patient complained of great dryness in the nasal pas-

sages, aconite when the prevailing weather was dry and cold, gelsemium when exudation had already started and the patient looked and felt "bum," mere. bijod. when the tonsils or Eustachian tubes were involved. After the disease had become well established, he preferred kali bich. when the discharge was thick, sang. nitr. if "stuffiness" was a prominent symptom, ars. iod. when the discharge was profuse and very acrid, populus when there is coexisting hoarseness, phosph. when the nasal discharge has an unpleasant odor, and thuja when there is evidence of marked atonicity of the mucous membranes.

In the chronic forms of nasal catarrh the doctor has little confidence in the action of medicines, unless assisted by measures looking to the disinfection and cleansing of the nasal passages. In those cases in which the nasal catarrh was dependent upon a constitutional taint, such as syphilis, gout or rheumatism, remedies alone were often effective. He referred to cases of nasal catarrh kept up apparently by a condition of hepatic hyperæmia, and in which remedies addressed to the liver state had helped the nasal catarrh.

In the nasal catarrhs of syphilitic subjects, he spoke favorably of mercury, kali iod., kali bich., aurum mur., natrum mur. and nitric acid. Pulsatilla had been very effective when the discharges were thick and bland, and when marked dyspeptic symptoms were present. Unless a case of acute rhinitis can be aborted upon the first or second day, the speaker was not in favor of local measures, especially if there was any tendency for the catarrhal process to extend downward to the bronchi. If there is a coexistent bronchitis, he was strongly in favor of letting the nasal symptoms alone, as in his experience the bronchitis was much longer in getting well in those instances where the nasal condition had received local treatment. He was fond of noting that during treatment, as the bronchial catarrh disappeared, very frequently a nasal catarrh would reappear, and he regarded this as favorable, and not to be interfered with. The speaker urged the specialists to recognize the importance of a discriminating survey of the whole patient before beginning local treatment of any case of chronic nasal catarrh, and dwelt upon the frequent coexistence of Bright's disease, phthisis, or dilated heart and nasal catarrh in these patients. He concluded with a strong plea for the recognition of the habit of mouth-breathing, and its ætiological relation to nasal catarrhs.

O. S. Haines, M.D.

THE RATIONAL TREATMENT OF TYPHOID FEVER.—Hopkins, of Cleveland, in the *Medical Century* for December, 1900, thinks that "homœopathic treatment has probably won as much reputation for itself, as a system, in the treatment of typhoid fever, as in any department of medicine." He admits that homœopathic practitioners have obtained brilliant results from their well-chosen remedies in this disease, but further than this, he believes, or at least we infer that he does, that if they will secure an antiseptic condition of the intestinal canal by the administration of the sulpho-carbolates, especially the sulpho-carbolate of soda, while at the same time administering the proper remedy, they will obtain such results as have never before been secured. This intestinal antiseptic is recommended in five-grain doses. Dr. Hopkins' experience with this combined antiseptic and homœopathic treatment tends to prove that, while it materially lessens the death-rate, financially it is a bad thing for the doctor, because it at the same time materially lessens the necessary number of his visits. Enthusiasm is contagious, yet we do not believe

that the homœopathic profession, as a whole, will warm up to any extent over this announcement. It is more than probable that the majority will be content to go right along, obtaining the old "brilliant results" that the doctor has referred to. The therapeutic indications given in this paper are concise and excellent, and show that the writer is a good homœopath, but simply off the scent.

Bryonia.—Good remedy at the outset, unless another is clearly indicated. Dry intestinal mucous membrane. Frequently aborts cases.

Baptisia.—Profound cerebro-spinal depression. Putrescence of mucous membrane.

Gelsemium.—A malarial element, great debility, prostration, chills, prodromes.

Belladonna.—Characteristic pounding headache, throbbing headache.

Rhus tox.—Intestinal ulceration, involuntary stools, besotted face, restlessness, abdominal distention, great exhaustion.

Phosph. acid.—Nervous wrecks, mental depression, apathy, listlessness, catarrhal enteritis, abdominal distention.

Pulsatilla.—Discouraged, loathes everything, even water.

Cantharis.—Irritability of mucous membranes, marked thirst, tympanites, tender abdomen, vile bloody stools.

Hydrastis.—Jaundice, coated tongue, offensive breath, nausea, vomiting, constipation.

Hyoscin hydrobromate.—Destructive delirium, causing death by exhaustion.

Passiflora.—Even better than hyoscin for same indications.

Terebinthina.—Smooth, red, glossy tongue; tympanitis; great languor and prostration, muttering delirium, copious hæmorrhage.

Mercurius.—Slimy, bloody stools, with tenesmus.

Hamamelis, *Ipecac* and *Ergot*, according to indications, for hæmorrhage.

Yet it must be said, albeit it may seem unkind, the homœopathic physician cannot select his remedies for typhoid fever cases upon such indications as those given, for the reason that the peculiar, characteristic and unusual symptoms and signs by which alone he may accurately differentiate one remedy from another are not present. Most of the indications given are but commonplace, not differentiating symptoms.

O. S. Haines, M.D.

RATANHIA: A STUDY.—As Dr. W. A. Dewey says (*The Clinique*), our ophthalmologists and rectal specialists ought to be interested in this Peruvian plant, because it cures two ailments that are sometimes very troublesome: pterygium and anal fissure. It cures them according to the law of similars in all probability, although Trousseau and Pidoux, after almost proving the homœopathicity of its relationship in their writings, think that "it cures *because it cures*," an explanation anciently feminine.

One of the symptoms produced in the provings was a sensation as if a membrane was growing over the eye, with burning pain and a conjunctival inflammation. It has cured a number of cases of this disease. Dr. Hughes cured pterygium in the cat and dog respectively with the remedy.

Another seat of the action of ratanhia is in the rectum and anus. The symptomatic indications for the remedy may be summarized thus:

1. The anus aches and burns for hours *after* stool.
2. Constriction of anus requiring difficulty to force the stool.
3. Relief from application of hot water to parts.

Nitric acid has been a rather dependable remedy in the treatment of anal fissure; here the pain is felt *during* the passage of the stool. The pains of nitric acid are frequently sharp, splinter-like or cutting. Constant weight, pressure and constriction in anus. Moisture and soreness in anus and between nates when walking.

Peonia is mentioned by the author as a remedy to be considered in fissure. We have never used it in such a condition, but find very suggestive indications in its pathogenesis as given in Hering's "Guiding Symptoms."

Burning in the anus for hours after a stool, oozing of an offensive moisture from the anus, are the ones Dr. Dewey especially mentions.

From some experience that we have had with the *ratanhia* it seems likely that it will be useful in some cases of hæmorrhoids; which, by the way, are not always a surgical affection. The late Dr. Lippe cured toothache during pregnancy with *ratanhia*. He claimed that an aggravation during the night, compelling the sufferer to rise and walk about, was a reliable indication.

O. S. Haines, M.D.

MEDICAL HERESIES.—Douglass Caulkins, of Knoxville, Tenn., in a breezy little article recently published in the *Medical Century*, bemoans the fact that our grand and glorious profession is shackled by hands and coerced by traditions, that the spirit of intolerance still stalks abroad, that we as physicians are still bound down by the laws of custom or of sect, so that if a disciple of Hahnemann, in an emergency, resorts to castor oil he is sternly rebuked by his orthodox brethren and pointed to the narrow way that leads to Farrington and to Allen. All of which makes us think of what Emerson said about such matters: "People grieve and bemoan themselves, but it is not half so bad with them as they say." A strict adherence to the law of Homœopathic Therapeutics never has lessened and never will curtail the liberty of any man. If the cause of an illness be a fæcal impaction, we have the authority of the *Organon* to justify us in removing the cause by the best means at our disposal. If Dr. Caulkins prefers castor oil in such an emergency as this, he may use it, and he will not be criticised. Hahnemann said in his *Organon*: "When the physician knows in each case the obstacles in the way of recovery, and how to remove them, he is prepared to act thoroughly, and to the purpose, as a true master of the art of healing." Dr. Caulkins's paper is a plea for liberality. By all means let us be liberal, but let us not be lawless. As the author remarks, "Let him who tries to heal choose that which will serve his purpose best." This may not always be the homœopathic similimum. The late Carroll Dunham was fond of saying that the physician could not always act toward his patient in the capacity of the therapist merely, because the practitioner of medicine, in the exercise of his profession, performs many functions. If he acts as a surgeon, let his handiwork be faultless and his technique modern. If he acts in the capacity of obstetrician, let his methods be those of an up-to-date, aseptic midwifery. And finally, if he acts in the capacity of a homœopathic therapist, let him do his work according to the law of homœopathic therapeutics. That's all there is to the matter.

O. S. Haines, M.D.

BELLIS PERENNIS.—In the December *Medical Century* (which, by the way, was a very interesting number) Dr. W. A. Dewey has gathered from various sources, under the above title, about all the available knowledge of the action of this remedy. The *bellis perennis* is the English daisy, and it is destined perhaps to occupy an unique niche in our *Materia Medica*. Enough is now known regarding its medicinal virtues to make it quite useful. Dr. Dewey, in his article, shows that its efficacy in curing wounds and contusions was known to the ancients; indeed, it is said to have been named *bellis* “because of its fame in healing the wounds of soldiers.”

In 1858, Dr. Thomas, a homœopathic physician, recommended it, externally, in sprains and felons, and claimed that it was superior to either *arnica* or *rhus*. Thomas proved the remedy, and succeeded in producing boils on the provers. Burnett, of London, published in 1884 another proving, and later, in 1890, still another one. A study of these provings shows that the drug affects prominently the *left side* of the body. Fullness of the veins of the left side of the head and stabbing pains in the left hypochondrium. It also produced catarrhal symptoms, coryza, and feeling of exhaustion, the prover wishing to lie down. It produced marked vertigo, a sensation of swimming, in the head. Its action upon the skin was pronounced. Many boils, with mattery heads, pimples on the face with itching and swelling of the cervical glands, a “rash similar to barber’s itch,” swelling of the eyelids and face, simulating an erythema. It interfered with the sleep of the provers, the symptom reading, “sleeplessness in the morning, after three o’clock.”

Therapeutic Indications.—The *bellis* is probably better than *arnica* or *rhus* in some sprains and contusions, or for some of the effects of traumatism. Thus, in the case of a tumor of the left breast, produced by an injury, in which there was pain, swelling and tenderness, it cured most rapidly. It also cured “a tumor” of the upper jaw, hard and painful, the result of an injury. It promptly relieved the bruisedness and tenderness brought on by the passage of gall-stones. Dr. Burnett thinks that it is a superior remedy for the condition known, familiarly, as “railway spine.” It has acted, after failure of *arnica* in women after confinement, when the uterus and whole pelvis felt sore and bruised, and the patient was unable to walk in consequence. In the latter months of pregnancy, when the woman is unable to walk on account of soreness of abdominal walls and uterus, *bellis* is a remedy that may be depended upon to relieve. In the giddiness of elderly people, especially noticed upon stooping and rising, the remedy is excellent, as we have cause to know.

Bellis will, it is said, prevent the development of a crop of boils, if given when they begin to appear. If this be true, it is enough to win for the remedy a cordial welcome, for furunculosis is sometimes a formidable ailment. We have known a single robust boil to make the language of the learned man quite irrelevant. *Bellis* cures boils homœopathically. It has also cured facial acne, as well as inveterate psoriasis.

It is a capital remedy for the varied effects of a sudden chill from wet-cold, while the body is in an overheated condition. Likewise for the ill effects of taking cold drinks when overheated. Thus, it has cured enlargement of the liver, neuritis and diarrhœa from such causes. It is said to be a grand tonic

for the sexual organs, in five-drop doses of the tincture, and to be a good restorative for sexual fag. It will be well to accept a statement of this sort provisionally. There are better tonics for the generative organs than drugs. Those who have the felicity to suffer from the gout will find in the daisy a remedy which may quickly relieve the weakness in the limbs and the soreness of the joints, so common after acute attacks of that ailment. All these generalities tend to indicate to us that, when systematically proven, the bellis will be a valuable addition to our *Materia Medica*.

O. S. Haines, M.D.

CURE OF TUBERCULOUS ORCHITIS WITH TUBERCULIN 30.—Dr. Boesser, of Chemnitz, after referring to the report of a cure of an orchitis with tuberculin 200 by Dr. Man. Itzenoe, which appeared in the *Leipziger Populäre Zeitschrift für Homöopathie*, narrates a similar cure of his own. A merchant of about 35 years of age, who had suffered for several years from pronounced tuberculosis of the lungs, in which the presence of tubercle bacilli had been repeatedly demonstrated, applied for treatment of an acute orchitis. Being able to exclude gonorrhœa as the causative factor, and being inclined to ascribe it to the result of pressure, Dr. Boesser first prescribed *arn. 6x*, with absolute rest in bed. After 24 hours' use of the remedy there was no improvement. Slight fever was present; headache, great weakness and severe pains during the whole night, preventing sleep. The inflamed testicle became more and more swollen, with involvement of the epididymis, with severe bearing pains in the region of the groin. With the idea that it was an acute tuberculous orchitis and epididymitis, the patient received about noon 10 pellets of tuberculin 30, to be dissolved in half a glass of water, and a dose to be taken every two hours. In the evening the patient was found without fever and without pain, which had vanished soon after the first dose. The swelling rapidly diminished, and in eight days the patient was able to be up and around his room, provided with a well-fitting suspensory. In 10 days the cure was complete. In view of this case and the rapid relief of an acute painful swelling of the knee-joint occurring in another tuberculous patient, the reporter concludes that in cases of chronic tuberculosis of the lungs acute diseases of other organs and parts of the body are apt to occur, which are also tuberculous in their nature, and can be cured by tuberculin in the higher potencies, and, conversely, where tuberculin effects a cure we can predicate the existence of tuberculosis.

In *Fragments of a Proving of Tuberculin*, by Dr. Nebbe, of Montreux, we find recorded pains in the joints of the hands, in the knees and in the hips. Weakness in the knees—various characters of headache—fever—pains in the testes and in the spermatic cord.

Dr. Neul gives also the following characterization of tuberculin: Tuberculin is the isopathic sulphur. It is closely related to all the antipsorics, which can follow it with great benefit. It awakens and heightens the powers of reaction of the organism more than any other remedy in our *materia medica*. Hence remedies following it are indicated in the high potencies. The reaction is decidedly stronger in women than in men. Where tuberculosis is localized in formerly so-called scrofulous affections, curative effects are seen even after the relatively lower potencies. These latter should, however, only be employed after the 1000, 500, 200 potencies have failed speedily to relieve. —*Zeitschrift des Berliner Vereins Hom. Aertze*, Dec., 1900.

THE HAHNEMANNIAN MONTHLY.

MARCH, 1901.

TUBERCULAR CYSTITIS.

BY BUCK G. CARLETON, M.D., NEW YORK.

Consulting Genito-Urinary Surgeon to the Hahnemann Hospital, and Visiting Genito-Urinary Surgeon and Specialist to the Metropolitan Hospital, New York City.

AMONG the recent investigations of the diseases of the urogenital tract, none have elicited more interest or been of more importance than the lesions produced by the bacillus tuberculosis. Statistics tend to prove that vesical tuberculosis is more prevalent in the male than in the female. The lesions usually occur before the fortieth year, and may be primary or secondary. They are frequently obscure, and their early symptomatic and diagnostic consideration requires accurate observation, with confirmation by very careful urinary analyses and associated bacteriological examinations. An individual with a chronic inflammatory condition—simple, septic, gonorrhœal or calculus—of the urogenital tract, especially if there is an associated tubercular family history, is particularly predisposed to tubercular infection. The bacilli may enter the bladder through hematogenic or lymphatic channels from some remote tubercular lesion in another part of the body, be introduced upon unclean sounds, catheters, etc., or be dislodged from a focus in the urethra and in some way be carried back into the bladder. If the mucous membrane of the bladder is healthy the germs will not necessarily infect the viscus. Tuberculosis of the kidney may exist for years without associated vesical inflammation, although the urine voided constantly contains pus, caseous matter, bacteria,

etc., but it may finally be unnecessarily inaugurated by some ill-advised instrumentation. An unhealthy condition of the epithelial lining of the inner bladder wall may so weaken its normal resistance to the action of the tubercular bacillus that infection may be easily produced. A tubercular bladder inflammation may disappear after the removal of a diseased kidney without special treatment being directed to the bladder.

With the possible exception of the ureters, tuberculosis may be a primary lesion in any portion of the uro-genital tract, particularly at the base of the bladder, in the prostate, the epididymis and in the kidney.

Pathologically, the mucous membrane becomes greatly congested and the bladder wall diminished in area and thickened. Ulcers are often present, being preceded by gray tubercles, composed of round cells, tubercle bacilli, etc., which may appear quite prominently upon the mucous membrane; they are usually located within the ureteral or urethral areas or occupy the trigone at the base of the bladder.

When a tubercular cystitis is secondary, the prostate, seminal vesicles, kidneys and epididymis are usually involved. Many of the secondary cases follow general tuberculosis of the kidney, or extend directly from the prostate and seminal vesicles. When secondary to general tubercular inflammation, little except palliation is to be expected from medication, though much is claimed for the iodoform treatment. Dr. E. Guernsey Rankin, in a personal communication, says that he has cured 15 per cent. of a certain number of selected cases of pulmonary tuberculosis in the wards of the Metropolitan Hospital with iodoform inunctions. I may here say that sero-therapy, which has been so much before the public as a cure for tuberculosis, was first hypodermatically used by Dr. James R. Wood in the Ward's Island Homœopathic Hospital in 1875; the hospital records give evidence of much benefit, and in one case a cure resulted from its administration. Dr. Martin Deschere has cured many chronic cases with calcarea, baryta carb. and mur., silicea marina in the 30, and tuberculin in the 100, and the acute and subacute forms with baryta and calcarea iodide.

Tubercular cystitis runs a chronic course, with acute exacerbations from various causes; the tubercular foci seem to have periods of activity and repose. Often the disease will slumber,

and even disappear, only to return again after some slight over-exertion or exposure. In the earlier stages the general health is not especially affected, and often it is not incompatible with long life. It develops insidiously, its symptoms are usually slight, and medical advice is rarely early sought.

The increased frequency in the calls to micturate during the day, due to congestion of the inner layer of the bladder wall, the result of infection by the tubercle bacilli, is generally the first symptom noticed by the patients. Often after two or three months they are compelled to rise several times during the night to empty the bladder. As the disease progresses the desire to urinate may become almost incessant, being most pronounced after meals and at night. Retention of urine may be an early symptom, but as the ulcerative stage advances and the deeper structures of the bladder wall and the prostate are involved, incontinence may occur. With this frequency of micturition there is often pain referred to the perineal region or middle of the penis, when the disease attacks a male. These locations of pain appear to have marked diagnostic significance. There is also pain before, during and after the act of micturition.

In more than one-half of the cases of uro-genital tuberculosis hæmaturia is the earliest symptom, and this is especially true when the primary location is in the bladder. The amount of blood varies; at first there may be some slight oozing from the rents in the congested blood-vessels of the mucosa sufficient to give the urine a rose-red or pink appearance, or the last few drops of urine voided may be quite bloody. Occasionally bleeding is quite profuse; it may be constant or interrupted, and will appear and disappear without apparent reason. It may be sufficient to exsanguinate or cause the immediate death of the patient. The presence of blood is usually more marked at the commencement and at the end of the act.

When the infection is sufficiently advanced to produce cystitis, the pain in the bladder becomes more severe, and may even be agonizing. If clots lodge in the internal opening of the urethra, tenesmus and retention may result, with the consequent deep full pain in the supra-pubic and perineal regions, which is only relieved by the natural expulsion of the clot or catheterization. In the early stages of tubercular cystitis the quantity of urine voided is increased; it may be apparently

normal in reaction and general clinical character, or slightly tinged with blood. The urine, as long as the mucous membrane is simply inflamed, remains acid; when the tubercular process advances to ulceration, pus will appear in the urine, which may still continue to give an acid reaction, but will be slightly dimmed or hazy. When pathogenic micro-organisms are present the urine will become dark and cloudy. The dark appearance of the urine may be due to the blood present. Clots, shreds of mucus, pieces of necrosed tissue, crystals of uric acid, the oxalates, epithelial cells and urinary casts may also be found. Tubercle bacilli are present in the urine before it becomes purulent, but rarely afterward. In doubtful cases repeated examinations should be made, and twelve hours before the urine to be examined is collected a vesical irrigation with a weak solution of nitrate of silver should be administered. This will aggravate the condition if of tubercular nature; the bacilli will manifest themselves, and can usually be demonstrated.

Cystoscopic examination is generally painful, and, as the fluid in the bladder is usually cloudy and bloody, and remains so even when the organ has been repeatedly washed out, the vision will be obscured and the results obtained will rarely compensate for the discomfort at the time, to say nothing of the unpleasant lesions and conditions which may follow. Cystoscopic examination in selected cases may be of value in showing the presence of tubercular lesions or establishing their absence. As a rule, however, examination with the sound, catheter, cystoscope, etc., is not advisable, as it causes a great deal of pain, hæmorrhage, etc.

When there is a doubt as to the diagnosis, the family history should always be investigated, the lungs examined; and, in chronic cases of cystitis which fail to respond to general treatment, it is especially important to have a proper bacteriological examination made, and a guinea pig inoculated and examined to confirm or repudiate the suspicion. Fever with its characteristic evening exacerbation is rarely absent; there may be chills at the onset of suppuration.

From the above clinical symptoms tubercular involvement of the bladder is to be suspected when patients between fifteen and thirty-five years of age are annoyed with frequent micturition and slight hæmaturia, particularly if they have a tuber-

cular family history or tubercular nodules can be found in the epididymis, vas, prostate, lungs or other organs. Hæmaturia caused by a vesical calculus is relieved by rest; the reclining position aggravates the bleeding in tubercular cystitis. Tuberculosis of the bladder presents a clinical picture similar to that of a vesical calculus, but the tendency to frequent micturition in stone is relieved by rest, which does not obtain in tubercular cystitis; in vesical calculus, the reflex pain is referred to the glans penis (in the male), while in vesical tuberculosis it seems to be located in the centre of the penis or in the perineum. Tumors of the bladder occur in middle and advanced age; and, while they may bleed profusely, there is no increased frequency in the calls to micturate, as occurs in tubercular lesions. In women, hæmaturia is often the first symptom of tubercular cystitis, and is generally accompanied by a pulpy growth around the meatus urinarius.

When a tubercular condition of the kidney extends to the bladder, the clinical symptoms resemble closely those of renal calculus; when it extends from the seminal vesicles it stimulates vesical calculus, and presents as a clinical picture frequent desire to urinate, caused by a contracted vesical cavity; often in the early stage it will not contain more than four ounces of urine. In the last stages the thickening of the bladder walls may be so marked that the viscus will not contain more than one or two ounces. Pain is relieved when the bladder is half empty. The act of micturition is followed by a few drops of blood.

When the lesion originates in the prostate, in conjunction with evidences of acute prostatitis and hæmaturia, a rectal examination will reveal an enlarged nodular gland, etc. In tubercular cystitis retention of urine only occurs when the neck of the bladder or prostate is involved.

Primary vesical tuberculosis, if diagnosed sufficiently early, is fairly amenable to treatment. When secondary to other lesions the prognosis will depend entirely upon the location and degree of the primary lesion. In suspected cases, all instrumentation is contraindicated until careful urinary and bacteriological examinations have been made, as the improper or ill-advised use of instruments has frequently caused a slumbering tubercular condition to reawaken and become rapidly fatal.

For many years it was believed that until pus appeared in the urine the incessant desire to urinate did not necessitate a suprapubic cystotomy or other form of bladder drainage for the ease and comfort of the patient. Hygienic, climacteric, medical and general treatment were only advised. Recently it has been proven that when a tubercular cystitis is diagnosed early in its development, a suprapubic incision with curettement of the tubercular lesions, or application of lactic acid or the Paquelin cautery, and iodoform rubbed thoroughly into the diseased area, followed by drainage for a few weeks, with daily bladder irrigation with a solution of bichloride of mercury, 1-2000 to 1-20,000, results in a cure. Some prefer drainage by the perineal route. Cases of extreme tubercular cystitis have been reported where the entire bladder was removed and the ureters implanted in the intestine or in the rectum. Under no circumstances should a tubercular bladder be allowed to become over-distended, or the urine to become extremely acid or alkaline.

When operative measures are refused, urinary antisepsis may, with the homœopathic remedy as symptomatically indicated, constitute the entire treatment. Urotropin, which acts so well in many cases of chronic cystitis, should not be prescribed in tubercular conditions, as it produces irritation and polyuria, unless it is combined with the carbonate of creosote. Guaiacol, in three- to twenty-drop doses three times a day, or the same dose of creosote given for a long period, has acted kindly. With medicinal treatment a dry, clear climate should be selected for residence. Chilling of surface of the body should be avoided; the diet should be plain, nourishing and non-stimulating; rapid and over-eating should be prohibited, and fat food should be taken to the point of digestive tolerance.

When vesical irrigations to cleanse the bladder seem advisable, the hydrostatic method should be employed and the solutions evacuated per urethra. Normal salt or weak salicylate of sodium solutions are to be used; Guyon says that boric acid is injurious in all forms. After cleansing, instillations of ten to forty drops of bichloride, 1-5000-20,000, repeated every two or three days, has been well spoken of. Often emulsions of iodoform seem to be more beneficial. Jarmin advises and reports cures with an emulsion compound of 5 per cent. iodoform with vaselin, one or two teaspoonfuls

being injected every twenty-four to forty-eight hours. Picot recommends an emulsion composed of guaiacol, five parts; iodoform, one part; sterilized olive oil, one hundred parts; of which ten to twenty drops are to be injected daily. The latter is to be preferred, as vaselin has been known to furnish the nucleus for a vesical calculus.

While this is probably too early to express a positive opinion as to the application of surgical treatment to tubercular cystitis, from the results which I have obtained in my private and hospital practice during the past year I am convinced that the best interests of our patients suffering with primary vesical tuberculosis lie in a supra-pubic cystotomy, removal of the tubercular lesions, proper bladder drainage, rest, and the direct application of iodoform to the lesion. I have had no experience with lactic acid or the cautery, but in those cases of primary tuberculosis which have submitted to a supra-pubic cystotomy, where there was no involvement of other organs, I have been more than pleased with the results.

One of the last cases operated, which was complicated by an encysted calculus weighing 293 grains, may be of interest: The patient, Mr. H., was thirty-nine years of age, unmarried, and a painter by occupation. He gave no history of venereal disease. His first urinary symptoms appeared about two years ago, when he noticed that his urine was slightly discolored with blood. This subsided in a few days and did not occur again until twelve months later. Since the first attack of hæmaturia, he had increased desire to urinate day and night, and during the past three months the calls to micturate have been almost incessant, and so painful and distressing as to cause him to cry out. The pain was referred to both the fossa navicularis and to the middle of the penis. He appeared haggard, worn, and very much run down from the pain and frequency of the calls to micturate. His temperature in the evening was 100 degrees and in the morning 99. Dr. George T. Laidlaw found an abundance of tubercle bacilli in the urine. The examination before operation located an associated vesical calculus. The stone, which was encysted behind and below the trigone, was removed with considerable difficulty, a deep, ragged pocket, requiring special drainage, being left after its removal. Numerous gray tubercles were found on the bladder wall. They were

removed and the diseased bladder wall rubbed with iodoform. The space of Reitzer was cleared and walled off with a continuous catgut suture, holding the lower segment of the bladder wall to the muscular tissue above this space. The upper opening in the bladder wall was held firmly in place with a silk-worm suture passed through the integument, muscular tissue and bladder wall. This held the viscus well up, and prevented extravasation and insured proper rest to the walls. The silk guys ordinarily used to steady the bladder before opening it, and to draw the bladder well up afterward, were utilized to bring the lateral portion of the bladder opening up to the abdominal aperture and to retain it in position, preventing urinary extravasation, etc. Drainage by the Guyon method was continued for three weeks, and the bladder was irrigated daily with a bichloride solution, 1-10,000.

At the end of eight days the tubercle bacilli disappeared from the urine and have not returned; the temperature became normal, and the patient made an uneventful recovery.

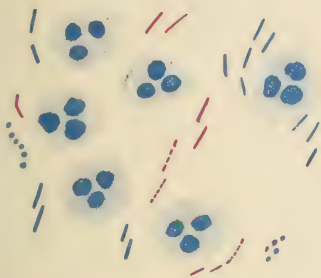
This has been practically my experience in all cases of localized tubercular cystitis. When compared with the previous unfavorable prognoses and results, we cannot but believe that much can be done for these cases, and if seen sufficiently early a cure can be reasonably expected.

THE URINE OF URO-GENITAL TUBERCULOSIS.

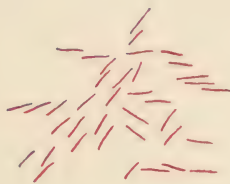
BY GEORGE F. LAIDLAW, M.D., NEW YORK.

THERE is no characteristic gross appearance of tuberculous urine. It may be clear or turbid, with or without sediment, bloody or purulent. It may be scanty or profuse, with high or low specific gravity, and present every possible variation in urea, uric acid and inorganic salts. The only diagnostic feature is the presence of the tubercle bacillus.

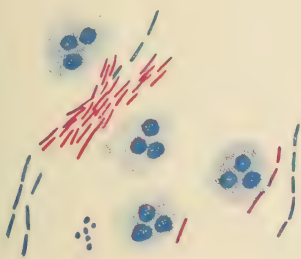
The search for the tubercle bacillus in urine is usually so arduous and unsatisfactory that the examiner seldom undertakes it unless the surgeon or physician requests it. For this reason uro-genital tuberculosis has seldom been found first by the urinary examiner. It is certain that many cases have re-



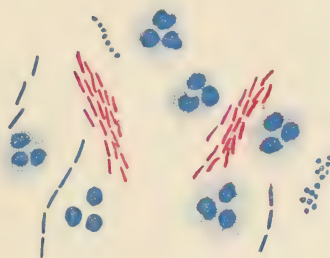
Tubercle Bacilli in Urine.



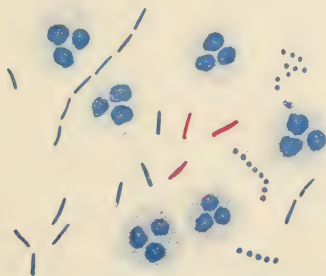
Smegma Bacilli from Smegma.
Stained by Ziehl-Neelsen Method.



Clusters of Tubercle Bacilli often found in Urine.



Edges of Air Bubbles.
(George F. Laidlaw.)



Crystals of Fuchsin resembling Bacilli.

TUBERCLE BACILLI IN URINE $\times 1200$.

Tubercle Bacilli, red ; other organisms, blue ; Pus Corpuscles, blue.
Stained by carbol-fuchsin, and decolorized by nitric acid and absolute alcohol.



mained unrecognized for months, or even years. That this is the case is shown by my own laboratory records, covering the past ten years. In the first five years, out of five thousand urines examined, only three cases of tuberculosis were diagnosed. In the next three years, out of two thousand urines, five were tubercular. In the last two years, of two thousand urines, there were twenty cases of urinary tuberculosis.

For the detection of the tubercle bacillus, a good centrifugal machine is essential. A hand-machine will do the work, but the electric centrifuge is a great deal better. I have worked with both, and know whereof I speak. I now use a Purdy electric centrifuge with great satisfaction. I have yet to find a urine which will not yield some kind of a sediment with it.

If the suspected urine is clear, or has very little mucus sediment, it may be centrifugalized without preparation and the sediment spread in the usual way—not on a cover-glass, but on the glass slide, and stained as described later. It is better to collect the urine for twenty-four hours, as one is more apt to find the bacilli thus than in a fresh specimen. Allow the urine to stand for from three to six hours and put the sediment in the centrifuge. If there is much light mucus sediment, centrifugalize four tubes and unite their sediments in a single final precipitation.

If the urine is cloudy with urates, they must be dissolved by warming the sediment in a beaker, keeping below the point of boiling. Centrifugalize in a warm tube and spread on a warm slide. After this no precaution is necessary, as any precipitate of urates on the slide will be washed away by the staining fluids.

The interference of phosphates must be managed by dissolving with five drops or so of acetic acid to one-half ounce of sediment.

Uric acid is seldom abundant enough to interfere with the precipitation of the bacilli. When abundant, it is not annoying, as the heavy uric acid crystals go quickly to the bottom of the tube, while the lighter corpuscles and bacilli rest above them.

When abundant, oxalate of lime presents an obstacle. Solvents of the oxalate may destroy the bacilli. The best plan is to spread on the two slides a thick layer of sediment, oxalates

and all. When they are dry, rub them together to thin down the film, and the heating over the flame will do the rest.

Pus is the most troublesome sediment to manage. When abundant, it fills up the centrifugal tubes, and the bacilli do not readily precipitate through it. For this difficulty I devised the following manipulation: To the pus, add one-fourth of its volume of liquor potassæ and warm gently in a beaker, agitating it. The pus will coagulate and then slowly liquefy. Precipitation at the highest attainable speed will bring down a soft, bulky sediment, at the bottom of which the bacilli will be found. On several occasions I have had the satisfaction of finding the bacilli with this method after they had been sought in vain by other examiners, and where the accuracy of the diagnosis was confirmed by operation and inspection of the tubercular areas. It is to be remembered that too strong an alkali will destroy the bacilli, and it is sometimes impossible to find them in strongly alkaline, gelatinized, tubercular pus. I have determined by experiment that they resist the action of liquor potassæ in equal volume, and also one-sixth volume of a 40 per cent. solution of sodium hydrate, and one-sixth volume of aqua ammonia. In purulent urines I invariably examine the sediment before treatment with potash, as well as after.

Treat bloody urine in the same way as the purulent.

Having described the methods of bringing the bacilli on the slide for staining, it remains to outline the staining procedure, and to describe the objects which may be mistaken for tubercle bacilli. Have ready a bottle of Ziehl-Neelsen (carbol-fuchsin) solution,* a pipette, a wide-mouthed two-ounce bottle filled with 20 per cent. nitric acid in water, a beaker or tumbler of clean water, absolute alcohol, a 1 per cent. watery solution of methylene blue, and a wooden clip of some sort with which to hold the hot slides.

The films on the slides should dry thoroughly in the air without warming. They are thus less likely to wash off. They must then be fixed by passing over the Bunsen burner slowly three times. An alcohol flame is not hot enough. Holding the

* The carbol-fuchsin solution can be purchased in the drug trade; or it may be prepared by adding a drachm of a 10 per cent. solution of fuchsin in alcohol to one ounce of a 5 per cent. watery solution of carbolic acid. Each solution should be filtered before mixing, and again afterward.

slide in the wooden clip, cover the hot slide with the carbolfuchsin solution, and let it simmer gently for two minutes. Pour off the fuchsin and immerse the slide in the water for ten seconds. Then dip the slide in the nitric acid solution, in which it loses all its red color. The time in this solution will vary with the intensity of the stain, and must be judged by experience. Generally twenty to thirty seconds suffice. Immerse again in the water to wash off the excess of acid, and cover the slide with absolute alcohol for three successive times of one-half minute each. The alcohol decolorizes the smegma bacillus which often occurs in urine, and is indistinguishable from the tubercle bacillus when stained with fuchsin. Immerse again in water to wash off the alcohol. Next cover the slide with the methylene blue for one minute. Wash off the blue, dry the slide in the air or over the flame as desired, place a drop of immersion oil on the dried film, lower the immersion lens into it, and the search for the tubercle bacillus may begin.

As shown on the colored plate, the tubercle bacilli appear as red rods, straight or slightly curved, and sometimes beaded. The color is a light or dark red, according to the intensity of the staining. In the urine they are often found in dense groups, as shown in the middle of the plate.

Crystals of fuchsin resemble bacilli in form, and often retain their red color in spite of the nitric acid. On slowly changing the focus of the lens, the fuchsin crystal presents a middle streak of yellow with thin black borders. The tubercle bacilli are solid red with any focus. As shown in the plate, the broken edge of a large air-bubble or forked cracks in the film may imitate bacilli closely, as they often present a red color, especially when the decolorization with acid is imperfectly carried out. They can be recognized by following along the line of the bubble or crack. It is unsafe to diagnose anything as a tubercle bacillus which lies exactly on this line. One must search further for more conclusive forms.

The beginner should not be too hasty in making his diagnosis. Only patient and persistent study of the slides will train him to accurate judgment. It is certain that this work will be required by the surgeon more and more in the next few years, and the writer gladly lays the results of his own labors before those whom it may concern.

ECTOPIC GESTATION: A SHORT STUDY OF CASES.

BY IRVING MILLER, M.D., BALTIMORE, MD.

MY experience in this pathological lesion is confined to twelve cases, all of which were operated upon by me in the last four years. The diagnosis was made in all but two prior to the operation, and it was confirmed, not only macroscopically, but also by a regular order of microscopic examination that I made in each case. Unless chorionic villi were found, I have not included them in this series. Tait, in his dogmatic manner, said all ectopic gestations were primarily tubal; and were I to be guided by my own experience I would be compelled to agree with him, for all of my cases were primarily tubal. I am also able to report but one constant lesion as being possibly the cause of an ectopic gestation, and that is a previous inflammation either in or around the tube. A history of pelvic inflammation of greater or less degree was obtained in nine of the cases, whilst all gave a history of previous sterility. One, being unmarried, makes the only exception. I did not find destruction of the tubal epithelium; toward the uterine end of the tube it was practically intact, and gradually became lower from pressure, until destroyed where the dilatation was greatest. Not one of the cases had either hydro- or pyosalpingitis either in the opposite tube or in any portion of the implanted tube. The infection in all of the cases was not of recent origin, except where it was a post-tubal rupture or abortion. Bands due to inflammatory adhesions limiting the lumen of the tube were present in five cases; in four the tube was fixed by surrounding inflammatory adhesions. Three tubal abortions also were associated with large hæmatoceles, whilst the two ruptures did not have such complications. A very typical tube constricted by inflammatory bands is seen in the illustrations. Conclusions drawn from my own observations are that tubal pregnancy is due to an interference with the passage of the impregnated ovum in some part of the Fallopian tube, and that this interference is due to adhesions and constricting bands

produced by a previous inflammation, or a congenital anatomical peculiarity. Many of these cases go unrecognized. The day, however, is past when the gynaecologist is not trained in pathology, and the class of cases that are discussed in this paper are only recognized upon an accurate microscopic examination. Chorionic villi were found in all cases where other evidence was lacking, or else the case is not reported as an ectopic gestation. A foetus was not found in three tubal abortions.

Only four authentic ovarian pregnancies have ever been reported, and I question the intra-ligamentary forms, for it is easy to mistake the pseudo- for the intra-ligamentary; nevertheless, such mistakes need not occur, for, as Kelly says, the ovary is always found embedded in an inflammatory mass when it is of a pseudo-intra-ligamentary type, and a line of cleavage is usually found that demonstrates its true character, whilst the intra-ligamentary will have ovary on the top of the tumor. Whilst the symptoms may vary, nevertheless an ectopic gestation has a fairly constant history; and, with the knowledge we have to-day of the lesion, it is seldom diagnosed erroneously. Not any single symptom is diagnostic; it is the association of the various symptoms that completes the picture. Eleven in this series considered themselves pregnant; only five had the ordinary signs of pregnancy, such as nausea, morning sickness, stopping of the menses, painful breasts, and the soft cervix in association with the bluish color of the vaginal mucosa. Each, however, who had experienced former pregnancies volunteered the information that her feelings were not the same as before. All complained of an uncomfortable, heavy feeling in the lower abdominal region; and eight, of the pain as agonizing. When rupture occurred, the picture was one of shock and hæmorrhage. The physical examination may find a uterus enlarged to the dimensions of a six weeks pregnancy; but, to me, the size of the uterus does not indicate anything. Decidua vera is found when the curettage has been examined.

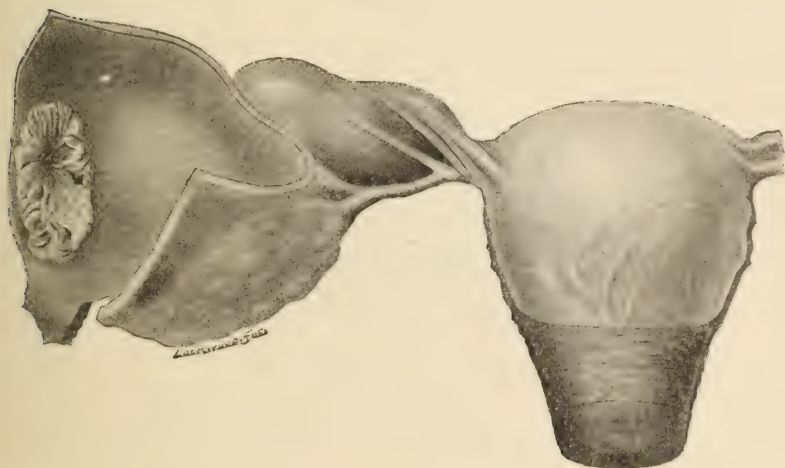
When this decidua is cast off it is usually considered to be an abortion. A tumor is felt springing from the side of the uterus, or it may, as in two of my cases, have a distinct pedicle, which, however, is the Fallopian tube and utero-ovarian ligament. There is a little more elasticity about the tumor than

we find in abscesses in this region, but the general feel to me was one of a rather firm consistency. The mass is painful to the touch, and if a hæmatocele is present the proportions are sometimes quite great. Hæmatocele may give a doughy sensation to the finger, but this is not a symptom present except when it has recently formed or ruptured. The tumor continues to grow, and is frequently first discovered by the patient. A case sent to me by Dr. Barclay illustrates this point. Mrs. A., age 30; married six years; miscarried the first year of her marriage, and suffered from an attack of "pelvic cellulitis" (?). Menses prior to this illness were normal; since had suffered with dysmenorrhœa and a very irritating leucorrhœa. In September, 1896, her menses were one week over time. One evening she was suddenly seized with a severe pain in her abdomen, fainted, became cold and pulseless with profuse sweat. She was revived with difficulty, and at this time a flow appeared that she considered her menses. She remained under the care of a local physician for several months, but was unable to leave her bed.

In January, 1897, she discovered a lump in her abdomen. Dr. Barclay saw her on March 1st. I saw her the next day, and found a tumor filling the cul-de-sac and springing from the left side of the uterus, appearing just above Poupart's ligament and reaching to the median line on the right, nearly to the umbilicus above. The mass was firmly fixed, quite hard, and very sensitive to pressure. The ovary and tube could not be distinguished. The cervix was hard, up under the pubis. She complained from the first of a severe boring, agonizing pain in the left side and radiating down the leg, the pain being so severe at times that she would be nauseated. She had a temperature varying from 38° C. to 39° C. Leucocytosis count, 14,000. Hæmoglobin not estimated. The condition was considered to be a suppurating ectopic gestation, and was so stated. At the operation on the following day I found a tubal pregnancy that had aborted and become attached to the fimbriated extremity through inflammatory adhesions, an immense retro-uterine hæmatocele, as well as a large inflammatory exudate that bound uterus, rectum and intestines in one solid mass. The omentum was firmly attached to the top of the mass, and I resected at least a third of it before I exposed the relations of the underlying structures. The

rectum was torn in separating the adhesions, not through the mucosa except at one small point, and it was easier to follow a resource that I saw my great exemplar make use of, and that was to stitch the posterior surface of the uterus into the rent, and it proved to be successful in every manner. Recovery uneventful. A microscopic examination showed the usual chorionic villi in the tube, hæmorrhage, and inflammatory infiltration shown by the round cells and leucocytes present. The musculature of the tube was infiltrated with leucocytes at the original implantation, and the peritoneal surface shows in several places constricting bands of connective tissue, giving the

FIG. 1.



tube the characteristic kinked appearance. The infection having already developed, the tubal mucosa in the abdominal end showed the usual inflammatory changes. The second case I theoretically failed to diagnose the first day, or, in other words, stumbled on the diagnosis. Mrs. S., married twelve years; never pregnant; a well-defined attack of pelvic peritonitis after a curetting and forcible dilatation by a physician in New York, to relieve the dysmenorrhœa from which she had been suffering. I first saw her November 1, 1898, and she reported being pregnant, and to have reached the third month. She had missed two menstrual periods, and was near the third period. Some morning sickness, but several times she had fainting spells, preceded by a severe pain. Breasts painful. The cause of seek-

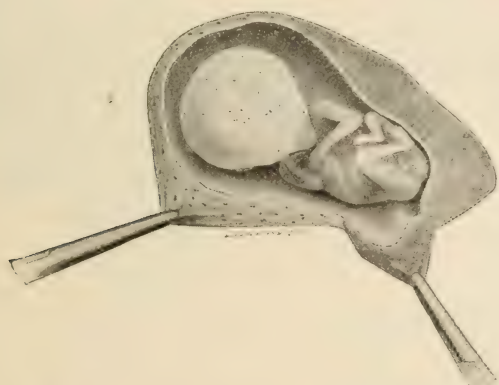
ing advice was that this day she had a severe pain in her abdomen, and the appearance of a rather free flow from the vagina. Her pains heretofore had been more of a boring character, but not sufficient to cause any decided attention. I considered it a threatened miscarriage, and when I examined her I felt a soft, patulous os and a globular mass in the cul-de-sac, but I could not tell whether it was the uterine body or a separate mass. As she was very anxious to have a child, I refrained from a more extended examination and ordered her to bed for twenty-four hours. The pains continued in severity, and the flow was of a pale, bloody character. Her temperature on the second day 39° C.; pulse, 102. Vaginal vault sensitive, and this globular body still so firmly connected with the uterus that it was considered a sharply retroflexed uterus, and this was the cause of the miscarrying. The next morning she was cleaned up and examined for the purpose of making a diagnosis as well as curetting the uterus, for I felt sure it was a miscarriage. The uterus was only 6 cm., and did not contain any foetus. I curetted, saving the specimen, and in a bimanual examination found the uterus shoved to the right; and springing from this left side, filling the cul-de-sac, and extending out into the left broad ligament, was this mass that previous to the etherization felt globular, and which I was sure could be only the fundus uteri. I could not feel the ovary of either side. So hard and fixed was this mass that I concluded, in association with temperature and severe pain, that it was an abscess, and proceeded to open by vaginal puncture. I opened up a large hæmatocele, and as the hæmorrhage was persistent I opened the abdomen, finding a tubal-ovarian pregnancy that had not ruptured. I removed this, and the course was uneventful. The illustration shows the foetus in the sac, and is the exact size. Of course, the tubal-ovarian site is the secondary implantation of the ovum. The scraping contained decidual vera.

A ruptured ectopic gestation is the next of interest, and illustrates most forcibly the importance of making a diagnosis and sticking to it. Mrs. R., age 40; 3 children; youngest child 10 years of age; several miscarriages; last miscarriage six years ago, when she had a fever for two weeks and suffered from a hæmorrhage of greater or less degree for several months thereafter. At her attending physician's request I curetted,

removing considerable debris of retained placenta. Two years after this I repaired a relaxed outlet, and found the uterus movable and practically normal, although she had never been pregnant since her last miscarriage. On April 3, 1900, her last menstruation commenced, and terminated on the 10th. On May 2d she suddenly experienced a severe pain in the right lower abdominal region. A point of exquisite tenderness being over the appendiceal region made it possible that this organ was involved.

The pain that she described was of a boring, bearing-down character, and radiated to the legs. A contracting pain of the uterus made her think it might be a miscarriage. This statement she volunteered, not giving any reason for so thinking.

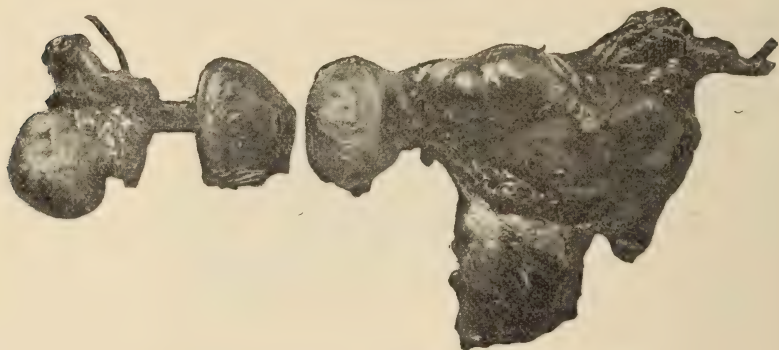
FIG. 2.



Temperature, 37.8° ; pulse, 120. I discovered in the right ovarian region a tumor connected with the uterus by a pedicle, quite movable, but very sensitive. So that with this history of sterility, a tumor connected with the uterus, a painful tumor, a boring, agonizing pain, a suspicion of pregnancy and a shock pulse made me think of ectopic gestation and demand an immediate operation, which was declined, and I immediately withdrew from the case. Two weeks after this consultation I received an urgent call from the husband to come at once. The patient about midnight, while having a stool, fainted, and while partially recovering consciousness, did not do so sufficiently to express any feeling of pain. When I saw her she was in profound shock, breathing heavily, livid, widely-dilated pupils, and pulseless. I opened the abdomen immediately,

found it filled with blood, and the right tubal extremity the rupture point. The drawing here shown is an exact reproduction of the fœtus and sac, the primary seat of the implantation being in the isthmus, whilst the secondary seat is in the fimbriated extremity; in fact, the appearance is as if it is caught by the fimbriated ends. The rupture is on the anterior surface of the sac. I did not find any venous coloring of the vaginal mucosa, she had not missed a single menstrual period, whilst it is very evident that the pregnancy is over three weeks. The symptoms, therefore, being a sudden severe pain, a tumor connected with the uterus, and sensitive to touch, the pain of this peculiar boring, agonizing character. She had an indescrib-

FIG. 3.



Left Tubal Pregnancy. Uterus Split and Trisected.

able feeling that she was pregnant, and the presence of a tumor.

The next case of interest is one of infection following a tubal abortion and ovarian abscess. Mrs. G., married ten years; no children; no miscarriages; supposed gonorrhœal infection ten years previous. She entered the Sanitarium in September, 1900, with a pulse of 130, temperature 40° C., and well-defined pelvic abscess. I opened the vaginal vault and evacuated the abscess, but in exploring the cavity I easily felt a thickened tube, and on the right side a mass that was an ovarian abscess. I removed the uterus and adnexæ through the vagina, evacuating an abscess of the right ovary, and in the left tube a clot that at first was thought to be a suppurating mass, but microscopic examination revealed some exquisite specimens of chorionic villi. So that here we have an in-

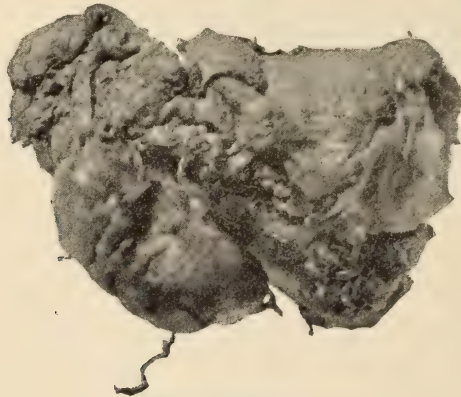
stance where the diagnosis depended upon the pathological report, and under no other circumstances should the condition be considered one of ectopic gestation. The leucocytes in this case were 20,000.

One more of my series I shall report in detail, it being a tubal abortion with a large hæmatocele. Mrs. C., sent me by Dr. Britton. She gives the following history: Age 30; two children; youngest 6; no miscarriages; menstruation always painful; flow profuse; last confinement had a fever ("child-bed fever"?). A profuse leucorrhœa since last confinement. Four weeks before I saw her, whilst attending a picnic, she was attacked with a severe pain in the lower abdominal region. This pain developed so suddenly and severely that she fainted, became cold, and in a profuse sweat. When she reached home, some hours after, a slight flow appeared that she supposed was the menses, menstruation having been delayed just nine days. A pain in the left groin commenced to annoy her as soon as she became conscious, and continued of this agonizing and boring character the whole of her illness. One week before I saw her she discovered the "lump" in the lower left abdominal region. I examined the woman on June 27th and noted the following conditions: A tumor just above Poupart's ligament of the left side, reaching above to the umbilicus, filling the left inguinal region and also hypogastric and inferior umbilical region, passing to the right of the median line nearly level with the umbilicus. A narrow zone of resonance on the left edge of the tumor. The uterus was crowded up under the pubis and to the right side. It required a long catheter to catheterize. Cervix hard, and fundus slightly anteverted. Vaginal vault filled with a hard, tense, sensitive mass. On the top of the tumor, and to the right of the umbilicus, a small, nodular, movable, sensitive tumor was easily felt. In fact, it raised up the thin abdominal wall in this spot. Leucocytes, 20,000. Nucleated red corpuscles. Temperature, 40° C. Diagnosis, ectopic gestation. Operated the next day, and exposed, upon opening the abdomen in the usual way, an immense hæmatocele of the left broad ligament that had dissected up the peritoneum of the rectum and sigmoid, as well as the retro-uterine pouch. The nodule on the top and right of this mass was the left ovary, and the tubal ostium of the same side

was directed directly up toward the abdominal wall. A large amount of free blood in the cavity, large clots in both flanks, and oozing still present in the patulous tubal ostium. The hæmatocele contained 2500 cc. by measurement of blood clot. Much, however, was lost. I operated this case as I have done a number of adherent pelvic inflammatory cases in the past year.

The method is the quickest and most rapid of all others for masses bound down by adhesions, or any tumor where lateral space is limited and a quick control of the blood supply is demanded. I clamped the fundus uteri with two pair of museux. I split between, clamped still lower, and split the body until the level of the uterine artery was reached, then rolled out;

FIG. 4.



Tubal Pregnancy.

strong upward traction all the time being made, the cervix is cut across and the uterine artery easily exposed; clamping the artery before cutting and rolling the mass still further out, clamping and cutting the round ligament. The whole of the mass on the side is now easily rolled still further out and the ovarian vessels easily clamped. The remaining half is treated in exactly the same way, and six ligatures will control the whole blood supply. Adhesions are always easier dealt with from below up, and the bladder is usually out the way. This woman received 2500 cc. salt solution subcutaneously, 2 litres of the same left in the abdomen, and a stimulating enema in the rectum. Her pulse had a better volume than before the operation, and two hours after a full, strong pulse of 108.

Kelly was the first in this city to operate in the manner I have just depicted. The illustration shows the enlarged tortuous tube, constricting bands of connective tissue, the fimbriae thickened and infiltrated, but not adherent in any place, the ostium abdominalis dilated, and from it was escaping blood. The clot is the characteristic, partially organized cast of the tube. In the widely dilated fimbriated end the epithelium has disappeared, whilst toward the uterine end it is practically normal, and gradually becomes flatter, or rather lower, as the opposite extremity is approached. Mononuclear leucocytes and round-cell infiltration at the point of greatest dilatation and where the tubal wall is thinnest. Chorionic villi are in the section taken from the centre of the tube, or point of greatest dilatation. The villi are perfect, and could, if devoid of the musculature of the tube, be considered as being obtained from the uterine cavity. Hæmorrhage is in evidence in all the sections, and has destroyed the decidual cells. In but one place, where the coagulum is intact, do we find characteristic decidual cells.

A summary of the twelve cases shows the following characteristic signs.

1. All have a history of sterility.
2. Eleven had a definite history of previous attacks of pelvic inflammation, constricting bands and adhesions in each case being present. In four of the patients the tube in which the implantation occurred was bound down by inflammatory adhesions, whilst the remaining tube was normal.

In the five cases referred to, the lumen of the tube was decidedly limited by the inflammatory products. All complained of a boring pain, reaching sometimes to agonizing proportions. This pain was most severe in cases complicated by hæmatocele of greater or less proportions.

3. A sudden pain of great severity usually corresponded to the rupture, or secondary implantation.

The rupture in all of my cases did occur near a menstrual period. In one case straining at stool seemed to be the exciting cause.

Eleven considered themselves pregnant, but there was absence of menstruation in but five. All reported a peculiarity of the menstrual flow, such as paler, or less. A dragging pain in the lower abdomen was present in each case.

The proper treatment in each case is "abdominal section." The cause of an ectopic gestation is not known, various causes stated by various operators to the contrary, notwithstanding, and it is impossible to arrive at any definite conclusions from the literature published.

Do the tubal changes occur prior to or after the implantation of the ovum?

Not any of my cases offer any solution to the question, for in all either infection or hæmorrhage had made macro- as well as microscopic changes in the tube. Mandl and Schmidt, working in Schauta's clinic, reported in detail 77 cases, and endeavored to produce extra-uterine pregnancy in monkeys by binding the tube after fertilization of the ovum; they did not succeed till they bound the uterine cornua—their deductions being that the mucosa of the uterus was necessary for the nourishment and development of the ovum. Schauta reports 27 with a gonorrhœal history. The infection being of an ascending character, the periphery and tubal mucosa remaining normal, I was not able to obtain any very definite data on this point, except in one case that had a gonorrhœal history. Bouilly considers the changes to be caused by an inflammatory process of a subacute character, either endo- or perimetritis, producing changes in the tube, but not in the mucosa. Goebel two years ago, in a serial section of a tubal pregnancy discovered a number of epithelial covered cavities or diverticula of the tubal mucosa. Some of these diverticula he found ending blindly, and in one a fertilized ovum was found. He thinks this could be a mechanical cause. Bouilly and Baldy report cases in which menstruation was not disturbed at all. Bouilly notes the fact that the "flow" is seldom normal in character, a brownish or watery fluid instead of the natural bloody flow. Increase of temperature is usually considered a beginning infection, but Boyd thinks it often due to reabsorption of the blood in tubal abortion. Hirst considers the history and pain to be of great diagnostic value. The pain is in the lower section of the abdomen, radiating to the legs, and often of such a severe character that it causes nausea, vomiting, extreme weakness, cold sweat and collapse. This is also in full accord with my experience. Orthman did not find menstrual disturbances in all of his cases, whilst A. Martin

found them lacking in 32 per cent. Brettauer records an observation that I have observed, which is the comparative rarity of amenorrhœa, whilst an irregularity of the flow is quite frequent. It may be delayed 10 or 12 days, and appear as a hæmorrhage. The uterus increases a little in size at first, but the tumor continues to grow. Stahl reported a case in which vomiting was the most persistent and dangerous symptom. Fehling is about right when he considers it impossible to make a differential diagnosis between tubal abortion with hæmatocele and sacro salpinx purulenta. Orthman finds the cause for rupture in the bands of adhesions limiting the space, whilst Muret thinks the thinning is due to the infiltration of decidual cells and the artificial relations thus produced. Hæmorrhage is at first limited to the place where the egg is implanted. A passive distention of the tube does not cause rupture. It is a well-known fact that unskillful examination will rupture the sac, and one death is known to me from this cause. The proportion of tubal abortions is about eight times as frequent as rupture, and the incomplete abortions are more frequent than the complete.

The only treatment that I consider at all is operative, and I fear Thorn stands alone in the expectant handling of an ectopic gestation. Bouilly operates by the suprapubic way, whilst Segond, in large intra-ligamentary pregnancy and hæmatocele, opens the abdomen, locating accurately the tumor, and empties the clot through the vagina, according to the method originated by Kelly. Orthman commends the procedure I have described. The above is a short résumé of the most salient points brought out in the more recent literature.

THE PROGNOSTIC VALUE OF SYPHILITIC IRITIS.—Trousseau considers that syphilitic iritis is usually the forerunner of other grave manifestations of the general disease. Of sixty-one patients treated by him during the past seven years, he has been able to watch the subsequent history of forty. Of these, only six have so far escaped grave troubles. Nine have suffered from serious complications which have invaded the nervous system. Three became affected with general paralysis, twelve became tabetic, eight had cerebral complications of some type, and two died, most probably from syphilitic lesion.—*Annals d'Oculistique*.

THE DIAGNOSIS AND TREATMENT OF CANCER OF THE STOMACH.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA.

BEFORE surgical technique reached its present high status, the early diagnosis of cancer of the stomach was an unimportant clinical problem. It mattered little if the nature of the case escaped recognition, for surgical intervention—thus far the only radical treatment for malignant growths—was valueless. Now things are different. The surgeon stands able and willing to remove the entire stomach, if need be, providing we, the physicians, can give him reasonably reliable indications for such a radical procedure. Accordingly, numerous attempts have been made to discover pathognomonic symptoms of gastric cancer on the one hand, and, on the other, to construct a well-defined clinical picture that will enable us to recognize the disease before constitutional infection has taken place. These efforts have not thus far met with the success that the practical importance of the subject warrants; I doubt if they will ever meet with success if attention is confined to the study of individual symptoms. Many phenomena there are which are strongly suggestive of cancer, but none of them excepting the presence of a tumor having certain characteristics can be accepted as diagnostic. But such a tumor affords clinical information of little therapeutic value, because by the time the disease has progressed to the stage at which the growth is palpable, the case has passed beyond the realm of surgery, and a radical cure is impossible.

Our only resource, it seems to me, is to study the suspected cases in their entirety; in other words, to take the entire clinical picture, including not only the symptoms under investigation, and for which relief is sought, but also the previous state of health, and the manner in which the symptoms presented themselves. In doing this, however, one must avoid all tendency to diagnostic empiricism, and must rest content with observing all possible facts, and endeavor to interpret them on physiological and pathological principles.

A conception of the clinical history of cancer of the stomach becomes, therefore, an important matter. Nevertheless, one must bear in mind that numerous instances occur in which remarkable departures from the standard course are observed. The influences producing these atypical cases must also be studied. In a general way, it may be stated that they include the temperament and general health of the patient, and the location of the morbid growth—whether at the pylorus or cardia, or involving the body of the stomach; the stage of the pathological process, *i.e.*, whether or not it has advanced to the stage of ulceration; and the degree to which adjacent viscera are implicated.

The symptom group characterizing the typical case of gastric cancer includes the ordinary phenomena of indigestion, gradual loss of strength, emaciation, epigastric pain, vomiting, hæmatemesis, deficiency or absence of free hydrochloric acid and the presence of free lactic acid in the gastric contents, and occasionally the discovery of portions of the tumor—recognized as such by the microscope—and the presence of a palpable epigastric tumor. Of these, the discovery of cancerous masses in the stomach contents only is diagnostic. While the others are merely suggestive, taken in association, they may be regarded as invaluable.

The average case of gastric cancer first exhibits the phenomena of an ordinary dyspepsia, presenting morbid sensations after eating, loss of appetite, nausea, and gradual loss of strength. Then follow the other symptoms above enumerated. The progress of the disease is gradual, and is usually extended over a period of not more than two years. In the majority of cases death ensues within a year after a positive diagnosis is made.

Indefinite or indecisive as are the symptoms of the initial dyspepsia, even this early stage may offer suggestions as to the serious nature of the case. The usual diagnosis made at this time is that of subacute or chronic catarrhal dyspepsia, according to the duration of the case. But catarrhal dyspepsia nearly always yields promptly to well-directed dietetic and medicinal measures. If, therefore, despite treatment, the case grows progressively worse, our suspicion of cancer should be aroused. This I hold to be a very important point. The chief chance for error lies in the occasional resemblance of chronic gastric catarrh to a gastric neurosis.

Of the individual symptoms making up the clinical picture of cancer, pain is certainly the most important. There are very few cases indeed in which it is not present, and it is also an early phenomenon. At first it is mild, but it gradually increases in intensity, until finally it entails constant suffering. To appreciate the diagnostic value of epigastric pain, one should recall that the chronic diseases of the stomach having this symptom are but few in number, and include ulcer, gastralgia, and cancer. The pain of ulcer is typically aggravated by the ingestion of food, and disappears when the stomach is empty. Between the paroxysms of pain there is apt to be present a soreness or sensitiveness on pressure. The pain of gastralgia is paroxysmal. It is usually relieved by pressure or bending double, and presents no relation to the taking of food. The pain of cancer is practically continuous, though subject to exacerbations. It is often localized, and may be associated with some soreness on pressure. While it is usually aggravated by the taking of food, such aggravation is seldom as clearly defined as in the case of ulcer. Neurotic gastric pains, other than those of gastralgia, though often heard of, are seldom seen. In the vast majority of the gastric neuroses the subjective symptoms consist not of actual pain, but of simple distress, discomfort, or paræsthesia—a fact to which the sufferers thereof will testify, if they are forced to make the distinction between pain and distress. I feel that we are altogether too ready to make the diagnosis of gastric neurosis to gratify the commendable desire for a favorable prognosis. I believe that a severe, constant, fixed epigastric pain should always be regarded as indicative of organic, never of functional disease.

Valuable as is pain as a diagnostic symptom, exceptional cases will be encountered in which it is absent throughout the course of the disease. A most remarkable example of this was observed by me a number of years ago.

Miss G., aged 29 years, consulted me March 1, 1891. She gave a history of extreme nervous feeling in the epigastrium for the preceding three or four years. At that time she had more or less vomiting about one hour after meals. She never had experienced any pain, and she had not lost weight. Her appetite was poor. Under treatment, *Pulsatilla* mainly, she made a gradual improvement until the autumn of 1891, when

she disappeared from observation. In the latter part of September she sent for me. She reported that she had continued in good health until one month before, at which time she was visiting the World's Fair in Chicago. While there her menstruation ceased unexpectedly. The following morning she began to vomit, and this vomiting had been constant since that time. No food whatever was retained. She had undergone progressive emaciation and prostration until, when I saw her, she was literally a living skeleton, and had scarcely sufficient strength to raise herself in bed. She had not then, nor had she had at any time, pain of even slight degree. On her first visit to me in 1891 I looked upon her case as one of gastric neurosis, and, in view of her improvement under treatment, I felt the diagnosis to have been confirmed. The sudden onset of her present illness and the absence of pain led me to the belief that it, also, was of nervous origin—*anorexia nervosa*. The possibility of cancer was entertained; indeed that had been the diagnosis of her previous medical attendant—more, I believe, because of her prostration, emaciation, and persistent vomiting, than because of the totality of the case. The patient grew steadily worse, despite dietetic and medicinal treatment. A consultant was called, and he agreed with the diagnosis already made. The possibility of cancer was discussed but dismissed, as it was thought, in view of her extreme emaciation, that a tumor, if present, could not possibly escape detection; besides, the entire absence of pain spoke against malignancy. The failure to discover free hydrochloric acid in the vomited matter was not regarded as of much importance, as the observation was not made under test conditions. She died one week after my first visit. An autopsy performed by Dr. C. V. Vischer discovered a disseminated cancer of the stomach, the walls of the organ being not much thicker than normal. A diffuse malignant infiltration of the body of the uterus also existed. The mistaken diagnosis in this case arose from the failure to make a vaginal examination—made all the more reprehensible because the propriety of such an examination was discussed and dismissed as of doubtful value. The patient presented no pelvic symptoms during life.

In a case seen by me with Dr. Goodno, pain had been a prominent feature for several weeks. The patient was a man

of fine temperament, in no sense hysterical. His pains were certainly agonizing. He had not emaciated, but presented a peculiar pallor, which I have never seen in neurotic ailments. This led me to believe that the trouble, whatever it might be, must be organic, and not functional. At the same time, I was unable to suggest a diagnosis. An examination of the gastric contents showed somewhat diminished free hydrochloric acid. Later, Dr. Van Lennep was associated in the case, and the patient was examined under anæsthesia by him, Dr. Goodno, and myself, without detecting a tumor. The case progressed for several months, when a tumor became palpable, and the diagnosis was clear. Ever since seeing this case I have been impressed with the importance of the constancy of the pain as suggestive of an organic cause, especially of cancer. A case teaching the same lesson was that of an elderly gentleman, not at all of neurotic temperament, who had severe and constant renal pains. Examination under anæsthesia by Drs. C. M. Thomas, W. C. Goodno, W. B. Van Lennep, and myself, discovered nothing. He died several weeks later, and malignant renal disease was found to exist. This patient never presented a cachectic appearance.

The question of age of the patient is always an important one for consideration, as nearly all cases occur in subjects at or beyond middle life. Exceptionally, cases will be encountered running counter to this rule.

Of great importance is the duration of the disease. As already stated, cancer of the stomach ends fatally within two years, and frequently within one year. If, therefore, an obscure gastric illness continues for more than two years, cancer is almost positively negatived. Exception to this statement may be found in those cases of cancer occurring in persons who have been the subjects of ulcer or chronic catarrhal gastritis. The case of W. H. B., to be presented in detail hereafter, is an excellent illustration of this.

Loss of strength and emaciation are important symptoms in all cases of cancer, but their importance has been overestimated, so far as their diagnostic value is concerned. In the final stage of gastric cancer, at which time the diagnosis is already a matter of certainty, emaciation is always prominent, being due to the malignant disease itself, and to the associated dis-

turbance of digestion. Weakness, likewise, is of itself of but little value, because it is a concomitant of any organic indigestion lasting for any length of time.

Vomiting is as common a symptom as is pain. It is but rarely an early manifestation of the disease, and yet, as in the case of Miss G., it was the first and only symptom. Its character will be varied by associated circumstances. If, for example, the growth is so situated as to produce pyloric stenosis with secondary gastric dilatation, the vomiting will simulate that of the latter condition, and be of large quantities at a time but at long intervals. In case the tumor is at the cardiac extremity, food will be ejected almost as soon as swallowed, but rather by the act of regurgitation than by an active emesis. Other than these, no special significance is to be attached to vomiting in the course of cancer of the stomach. It may be present in malignant disease of any portion of the organ, although its incidence is much later, as a rule, when the growth involves the walls of the stomach, as distinguished from the orifices of that organ. There is no fixed relation between the vomiting and the pain. In some cases vomiting relieves the latter; in others it does not. It seems that vomiting is liable to relieve when the cancer has progressed to the stage of ulceration.

Hæmorrhage (hæmatemesis) may be a symptom of gastric cancer, but it is rarely a prominent one, and when present is of but little aid in establishing the diagnosis. It is a late symptom always, for it cannot occur until the growth has undergone ulceration. In some few instances the bleeding is observed to be profuse. Slight oozing of blood retained in the stomach until it undergoes changes (coffee-ground substances), and then vomited, is not uncommon, and is characteristic of some cases of cancer.

The value of a careful examination of the gastric contents under test conditions, *i.e.*, after a test meal, is not sufficiently appreciated. Free hydrochloric acid is so frequently absent from the gastric juice in cases of cancer that this symptom may well be claimed as possessing a high diagnostic value. It is in no sense a pathognomonic symptom, for it is regularly found in all diseases of the stomach characterized pathologically by atrophy of the gastric mucous membrane as chronic gastric

catarrh, dilatation of the stomach, and achylia gastrica. There are also some cases of cancer of the stomach in which free hydrochloric acid is regularly found in the gastric contents—usually in diminished amount, and very exceptionally, indeed, in normal quantity. The diagnostic value of this symptom is enhanced when it is studied in connection with the associated phenomena of the case in hand and the clinical features of other diseases in which it may occur, and also of those diseases which are liable to be confounded with cancer. The usual clinical problem is the differentiation of cancer and ulcer. The subjective symptoms may indicate either affection, and, no tumor being discoverable, the case will be a doubtful one; but the absence or diminution of free hydrochloric acid in the gastric contents will speak almost certainly against ulcer and in favor of cancer. Again, let the problem be the determination of the nature of a chronic indigestion with vomiting. There is neither pain, tumor nor hæmorrhage. Hydrochloric acid is absent from the gastric contents. While the case *may possibly* be one of cancer, it is *exceedingly improbable* that it can be such, for we have but the one symptom indicating that disorder. We must look to the other conditions capable of producing this symptom, and, according to the clinical phenomena, we will diagnose the case as one of chronic gastric catarrh, dilatation of the stomach, or achylia gastrica.

Lactic acid is found in the gastric contents with about the same degree of frequency as free hydrochloric acid is found absent. It is frequently absent when there is no free hydrochloric acid. The presence of lactic acid may be regarded as a most valuable diagnostic symptom, for, according to Schiff, in 92 per cent. of the cases in which it appears, the diagnosis of cancer of the stomach may be determined. The absence of lactic acid is to be regarded as a negative sign, possessing no diagnostic value.

The Oppler-Boas bacillus has been exploited as a most valuable sign of cancer. So far as I can see, its presence seems to be dependent upon the existence of lactic acid in the gastric contents; hence its significance must be the same as of that symptom.

Hemmeter, of Baltimore, has proposed a method of examination for determining the presence of cancer, a method the

technique of which impresses me as being decidedly crude, and which will hardly strike the conservative practitioner as being safe. "The procedure should be carried out in the morning before breakfast, when the stomach is empty. A soft rubber tube suffices, providing it has a lower and a lateral aperture, the edges of which scrape away the tiny elevations of the gastric mucosa when the tube is moved in and out of the mouth." This method he declares is free of danger, and not once in his experience has any pain, distress or hæmorrhage been produced thereby. Portions of the tumor are thus obtainable, and microscopical examination of the same makes the diagnosis certain. It is a fact that the mere washing out of the stomach for therapeutic purposes will frequently detach small portions of the growth, which may be subjected to microscopic examination. Bearing this in mind, one has a valuable diagnostic measure at his disposal; but as for blind manipulation of the tube with the predetermination to accidentally knock off portions of the tumor, the procedure should be mentioned only to be condemned.

The above remarks apply to the subject of diagnosis of cancer of the stomach in general. Notwithstanding their recognized value, cases in which a positive diagnosis cannot be made will be encountered. It is well, under such circumstances, to have in mind the clinical pictures afforded by cancer involving separate portions of the stomach. For this purpose we may study the symptomatology of cancer as affecting the cardia, the body of the stomach, and the pylorus.

Cancer of the Cardia.—A growth in this position soon occasions stenosis of the cardiac orifice; hence we expect dysphagia to be one of the first symptoms of which the patient makes complaint. At first the difficulty is limited to the swallowing of solid food, later to that of pulstaceous substances, and finally to liquids. Auscultation will show alterations in the deglutition sounds. If pain is present, and it usually is, it will be epigastric in position. Food not entering the stomach is ejected unaltered by a process of regurgitation rather than by active emesis, as already stated. When the cardiac stenosis is sufficiently advanced, some particles of food may be retained in the œsophagus, and there undergo decomposition, irritating that structure and producing some degree of inflammation. It

is always to be regarded as an important sign of cancer of the cardia, and when present may be detected in the following way, suggested by Einhorn: "A tube of ordinary size (not too narrow) is introduced into the œsophagus until about 1 or 2 cm. above the stenosed spot, and the patient is ordered to compress his thorax after a deep inspiration. As a rule, some contents now appear through the tube. Then close the opening, withdraw the tube, empty it, and examine the obtained contents as to appearance (macroscopical aspect), reaction, whether acid or not, whether containing lactic acid, hydrochloric acid or the ferments. Then take a tube of thinner calibre which can pass the stricture, and introduce it into the stomach."

Age of the patient and the absence, in the history, of causes capable of producing benign œsophageal stenosis or dilatation of the œsophagus are important. The tube, when withdrawn, should be examined most carefully for the presence of blood, pus, and particles of tumor.

Cancer of the pylorus early produces symptoms of obstruction at the pyloric orifice, and, necessarily, interferes with the proper emptying of the stomach. With the object of determining this point, we wash out the patient's stomach in the morning before breakfast, at which time the organ should contain no particles of food. By various means we should endeavor to determine the size of the stomach, for some degree of dilatation is nearly always present. The tumor, when palpable, lies to the right of the median line, and between the umbilicus and the ribs.

In *cancer of the stomach proper* the pain radiates into the back. Vomiting, as already stated, does not become a prominent feature until the disease is well advanced, and then the quantity of substances ejected is small. The tumor appears in the epigastrium to the left of the median line. The motor power of the stomach is but little impaired.

The data above given seem to me to include all the reliable information for determining an opinion in the early stages of cancer. Cases must occur in which, despite knowledge and experience, the physician is unable to reach a definite conclusion. Then the propriety of an exploratory laparotomy may be raised. Wonderful as have been the advances in abdominal surgery, and safe as is a simple laparotomy under ordinary cir-

cumstances, this operation should not be performed in cases of suspected cancer without due forethought. Acknowledged authorities are too apt to recommend it as free of danger. Einhorn alone stands as an exponent of the danger involved in simple abdominal section in patients the subjects of malignant disease. The great authority of Osler urges their performance for determining a diagnosis, although he adds that such patients often fail to do as well as their general appearances would lead us to expect. Privately, this fact is generally admitted by surgeons; but the literature is not in keeping with such views. Certainly, exploratory laparotomy should not be performed unless there is hope that the operation may be extended into one of therapeutic character.

Before proceeding to the manner in which patients with gastric cancer should be treated, I will presume upon the patience of my readers by relating the history of a case which proved an enigma to eminent authorities of both schools of medicine in New York, Boston, Baltimore and Philadelphia. The patient, W. H. B., aged 42 years, consulted me August 21, 1895. For five or six years before consulting me, B. had suffered from epigastric pains, which appeared about one hour after eating. These pains could be relieved by taking bicarbonate of soda or a glass of milk. In the preceding two months he had lost about fifteen pounds in weight. Notwithstanding medicinal treatment and an exclusive milk diet he grew steadily worse. He then consulted Dr. Max Einhorn, of New York, who found hydrochloric acid present in increased amount, and the total acidity of the gastric contents to be 90. There was no evidence of tumor. The vomited matters never contained any blood. The hyperacidity led Dr. Einhorn to state positively that the patient was not suffering from cancer. He advised the conventional treatment for ulcer, which was then carried out. The patient was put at absolute rest in bed, with rectal alimentation for the first week. Three times each day the patient received *per rectum* one glass of milk, one raw egg, and one saltspoonful of salt. Then there was a gradual return to gastric alimentation. In the course of six weeks Mr. B. was apparently well, and remained free from pain for three months, gaining in weight and strength throughout that period. Then his pains returned, but their features were different from those

presented on previous occasions. They were no longer relieved by bicarbonate of soda, even in large quantities. A course of rest and rectal alimentation failed utterly to bring about any amelioration of his condition. At the end of that period my examination of the gastric contents gave a total acidity of 35. He lost flesh, and presented an anæmic appearance. But this was not surprising, in view of the small quantity of food he took. Up to that time he had maintained a philosophical temperament; but then his nervous system began to show the wear and tear of his long illness, and he became quite morbid, his complaints being the main subject of his conversations. In the winter of 1896-97 there appeared a prominence beneath the arch of the left ribs. Consultation was then called, and the patient examined under anæsthesia, without discovering the signs of tumor. The rest treatment was again tried, but without avail. In the spring of 1897 he sought the opinion of an eminent old-school general consultant, who expressed the opinion that Mr. B. was neurotic, and was suffering from the effects of an ulcer which had healed, and that the pains were probably dependent upon adhesions or cicatricial contractions. He advised Mr. B. not to think of himself, to eat well of good, nourishing food, and, if things did not mend, to undergo an exploratory laparotomy. Indeed, he did not know but that the laparotomy might be a good thing for the purpose of relieving him of the effects of a healed ulcer. Returning to Philadelphia, he then consulted Dr. Van Lennep, who spoke positively against operation, as did Dr. Einhorn still later. The patient's health improved greatly during the summer of 1897, and in October he was married. In December he again consulted me, but in the course of a week he was urged to place himself under old-school treatment, and he accordingly consulted an eminent allopathic surgeon, who associated with him an equally eminent clinician. After ten days' study of the case they gave the opinion that the trouble was neurotic, and advised over-feeding. This plan not working satisfactorily, he returned to me in January, 1898. Shortly after this I discovered a tumor to the left of the median line in the epigastrium. At a consultation of all those interested in the case,—Drs. Goodno, Thomas and Van Lennep examining him with me,—it was decided that an exploratory laparotomy should be performed, and accordingly Dr. Van Lennep operated. Nu-

merous carcinomatous glands were discovered, and on the posterior wall of the stomach was a well-defined tumor growing from a cicatrix, which had caused the stomach to assume the shape known as hour-glass contraction.

In the numerous discussions on this case malignancy was often suggested, especially when the epigastric prominence appeared. The frequency with which cancer may be engrafted on an old ulcer was also borne in mind. Attention was paid to the diminished hydrochloric acid as compared with the increased acidity of 1895. At my last examination, in December, no reaction was obtained by the Gunzburg reagent. As one looks back upon the case, there was certainly much to suggest cancer; but the patient's excessive indulgence in tobacco and his careless eating habits, the long duration of his illness and his hypochondriacal tendency, led all hands astray. This case also teaches the value of constant pain, not improved by well-directed treatment, in suggesting the possibility of malignancy.

Treatment.—The treatment of cancer of the stomach resolves itself into the surgical and medicinal, or, as some may prefer to divide it, into the curative and palliative. Certain it is that if this dread malady is to be radically cured, it is, in the present condition of medical science, only by surgical measures that this desirable result may be effected. But the resources of surgery need not be limited to attempting a cure, for properly indicated operative procedures may do much, not only in the direction of prolonging life, but also in making bearable the remaining days of the patient's existence. But the proper surgical treatment and the selection of cases suitable for the same is a matter of nice judgment and surgical experience.

The medical treatment includes numerous hygienic measures and the administration of medicines according to well-defined indications. First, as to the diet. No hard and fast rules may be laid down to define the articles which the patient may and may not eat. Patients will vary greatly in this respect. A good general rule is to determine the articles which best agree with him, and see that he gets them. It is generally held that, owing to the absence of free hydrochloric acid from the gastric contents, animal food is not indicated. And this, in a measure, is true. But if the patient is limited too much in the selection of

food, his general nutrition and strength suffer. It is important, therefore, that he be fed as generously as possible, and to this end dilute hydrochloric acid may be given with animal food, to aid its digestion. In the early stages of the disease, milk in its various forms (peptonized, koumyss, etc.), eggs, poultry, oysters, bread, butter, fish, may be allowed, if found to agree. Late in the disease it is hardly likely that anything but liquid nourishment, as milk and broths, will be tolerated.

The internal remedies directed to the improvement of the patient's general and local condition are few in number, although special symptoms or groups of symptoms may call for the administration of one of many medicines. The catarrhal condition of the stomach suggests the use of *hydrastis*, which, moreover, has some special action in cancerous lesions in general. *Conium* has also been suggested as having a specific relation to malignancy. *Arsenic*, however, is the remedy above all others which influences favorably the progress of malignant growths. It may be given in tablets of the second decimal trituration, repeated at intervals of three hours. As to the benefit to be derived from *phosphorus*, I am greatly in doubt. *Carbolic acid* and *creasote* have their adherents. Personally, I have no confidence in their curative properties in this disease, although it is more than probable that *creasote* may be of some value in relieving the vomiting, as it does in many other gastric conditions.

The principal symptoms calling for palliation are pain and vomiting. In the early days of gastric cancer the pain may be regulated to a great extent by attention to diet; the patient will discover this fact for himself. Finally a period is reached when special measures may be directed to its relief. The incurable condition of the patient relieves us from any fear of inducing a drug habit by the continued use of pain-obtunding remedies. Of these, the preparations of opium stand at the head of the list.

Scapnia in doses of one grain, repeated at intervals of two hours, if the pain is sufficiently severe to call for that degree of frequency; *codeia*, as tending less than other opium preparations to the production of constipation, or even *morphia*, may be administered. The size of the dose and the frequency of administration is a matter of judgment for the physician. Certain it is that larger and larger doses of the analgesic selected

will be required, until finally the interests of humanity demand that the poor sufferer be kept constantly under drug influence.

Chemically pure *methylene blue* (medicinal) will be found at times to act as an analgesic. Sometimes it does even more than this, stopping, as it may, the progress of the lesion, and keeping the symptoms in abeyance for a period of many months. It should be given in capsule in three-grain doses, which may be repeated once or twice daily. It is well known that some of the aniline dyes, notably pyoktanin, have a beneficial influence over cancer in other situations.

For the relief of the vomiting there is nothing like lavage, for it not infrequently controls this symptom entirely, after the first séance. It must, however, be continued day after day, as long as the patient's strength will permit. It will aid the patient's general nutrition, if each washing is followed by the introduction of a generous allowance of some nutritious, easily assimilable liquid food, *e.g.*, a pint of warm peptonized milk. Sometimes the administration of small pieces of ice or small doses of iced champagne will relieve the vomiting, thus obviating the necessity of using the tube.

THE DISTINCTION OF CARDIAC DROPSY FROM THAT OF ADVANCED RENAL DISEASE.

BY F. MORTIMER LAWRENCE, M.D., PHILADELPHIA.

MANY cases of chronic interstitial nephritis terminate in gradual heart failure. The renal sclerosis does not reach the point where elimination ceases and uræmia ensues, but the heart muscle can no longer hypertrophy sufficiently to overcome by its exertions the increasing resistance in the general circulation. As a consequence, dropsy supervenes—not the evanescent localized dropsy of renal origin, but an infiltration that begins about the ankles, and gradually rises as it fills up the dependent portions of the body. When this has occurred, the physician examining the sufferer for the first time may well hesitate before he ventures an opinion. Not only is the dropsy of cardiac type; the urine is no longer the pale fluid, large in

quantity and low in specific gravity, which we associate with renal sclerosis; it is diminished in quantity, and by concentration it has become high-colored and of greater specific gravity. The dropsy-distended patient, often unable to lie down because of frightful dyspnœa, presents the picture of heart-disease, not nephritis.

In such a case differential diagnosis is not a matter of mere clinical curiosity. It may mean life or death to the patient, for if his lesion be primarily cardiac, wise treatment may restore and maintain compensation for a long time; but if it be renal, he must die. Prognosis and treatment alike wait upon diagnosis.

Distinction between the two conditions is often difficult, and may be for a time impossible; but it is aided by attention to the following details:

1. The history of the patient. If he present evidence of a gouty habit, and a history of excessive, often nocturnal, urination, and of such suggestively uræmic symptoms as transitory visual disorders, gastro-intestinal disturbances, etc., it renders probable a pre-existing nephritis. The heart case is more apt to give a history suggesting mitral disease.

2. The condition of heart and arteries. In both cases the cardiac area is enlarged, but in the renal patient there is evident hypertrophy, often enormous, of the left ventricle; the aortic second sound is abnormally loud, and the heart is still relatively strong, while the arteries are atheromatous and the pulse full. The cardiac patient, on the other hand, shows greater evidence of failure of the right heart, with weak pulse, distended veins, and little arterio-sclerosis.

3. The urine. Closely as the urines of the two patients may resemble each other, it should be noted that in the nephritic case concentration of the urine rarely carries its specific gravity above 1020, and the total daily urea-elimination remains very low. In the cardiac patient the specific gravity may rise to 1025 1030 or more, while the urea is not diminished so extremely.

4. Finally, rest combined with the administration of suitable remedies often restores compensation in the primary heart case, the œdema disappears, and soon the urinary conditions which suggested renal disease are found to have vanished. Then the diagnosis, though belated, is certain.

EDITORIAL.

MEDICINE IN THE NINETEENTH CENTURY.

HAVING at last arrived at the twentieth century, after much tribulation, uncertainty, and dispute, humanity is at present largely engaged in looking back over the century that is gone and congratulating itself upon the progress made, while it promises itself even still greater achievements in the future.

(Parenthetically remarked, it has always seemed to us truly pathetic the way in which man, floating between two eternities, seeks to gain a temporary foothold and seeming permanency in the silently rolling ages by his artificial divisions of time into years and centuries. To-day differs not from yesterday except as the difference is in himself.)

Journals and magazines are teeming with reviews of the past in all departments of science and art, a perusal of which fills us with wonder at the immense strides made in nearly every direction since the giant of progress has awakened from his long sleep. It was but a sleep, during which he was slowly but surely and almost unconsciously accumulating and assimilating the energy which he has displayed, especially in the last half of the century that is past.

To physicians a review of the progress of medicine is, of course, of paramount interest, and nowhere will we find an abler *résumé* than in the article on *Medicine During the Last Century*, contributed to the *New York Sun*, Sunday, January 27, 1901, by William Osler, M.D., of Johns Hopkins University. Being intended for the general public, it is entirely free from technicalities, and in a lucid and logical manner traces the gradual development and growth of the medicine of the present day on the basis of discoveries made in kindred sciences. It will be of interest to examine it somewhat in detail in order to learn the author's views as to the present standpoint of medicine and the direction of its future development.

After a few words of general introduction, he proceeds to

treat of the growth of scientific medicine, and finds, as "the most distinguishing feature of this the phenomenal results which have followed experimental investigations," especially in the physiological and pathological laboratories. After referring to the inevitable growth of specialism, and the vast improvement in medical schools, he passes on to the growth of preventive medicine. This section of his article includes the science of bacteriology and infection, its processes and results, and is a clear and concise presentation of the diseases associated with micro-organisms, the common mode of infection in each, and the possibilities of prevention or cure by the use of anti-toxines. "Thus bacteriological scientists, after years of laborious work in the face of much criticism and severe denunciation, may confidently announce that they have in their possession a magic key to one of nature's secret doors. The lock has been turned. The door stands partly open, and we are permitted a glimpse of the future possibilities to be attained in the great fight against disease."

Finally, in the section on the new dispensation in treatment, we learn to know the author's standpoint, and his hopes and expectations for the future. "The century has witnessed a revolution in the treatment of diseases and the growth of a new school of medicine. The old schools—regular and homœopathic—put their trust in drugs, to give which was the alpha and omega of their practice. For every symptom there was a score or more of medicines—vile, nauseous compounds in the one case; bland, harmless dilutions in the other. The new school has a firm faith in a few good, well-tried drugs, little or none in the great mass of medicines still in general use." "A new school of practitioners has arisen which cares nothing for homœopathy, and less for so-called allopathy. It seeks to study rationally and scientifically the action of drugs, old and new. It is more concerned that a physician should know how to apply the few great medicines which all have in use, such as quinine, iron, mercury, iodide of potassium, opium, and digitalis, rather than a multiplicity of remedies, the action of which is extremely doubtful." But "there is no limit to the possibility of help from the scientific investigation of the properties and action of drugs. At any day the new chemistry may give us remedies of extraordinary potency, and of as much usefulness as cocaine."

“One of the most striking characteristics of the modern treatment of disease is the return to what used to be called the natural methods—diet, exercise, bathing, massage, and hydrotherapy.”

The article then closes with a brief reference to three departures in the art of healing: the use of organic extracts, the use of antitoxines, and a “return to psychical methods of cure, in which *faith in something* is suggested to the patient.”

From this it will be seen that the author, although not denying the possibility of an enlarged reliable materia medica, founded upon the researches of scientific pharmacology, has no distinct advances in medicinal therapeutics to record. Whatever improvement in the treatment of disease has taken place has, according to him, been due, negatively, to the rejection of false theories of the nature of disease and the methods based thereon, and, positively, to the following out of the lines set by the results of bacteriological investigations—the drug treatment of disease being as yet, except in some few instances, uncertain and unreliable.

Of course, in writing of medicine in the past century it would have been impossible entirely to ignore the manifest influence of homœopathy. Let us see in how far our otherwise logical author recognizes this influence. In the beginning of his article he says, “In a certain measure Hahnemann’s theory of homœopathy was a reaction against the prevalent theories of the day, and has survived through the century, though in a much modified form. Some of his views are as follows.” He then gives a condensed statement, by A. Jacobi, of the most ultra Hahnemannian views, and closes by saying, “Such is the homœopathy of Hahnemann, which is no longer recognized in what they call homœopathy to-day.”

Farther on we have “The battle against poly-pharmacy, or the use of a large number of drugs (of the action of which we know little, yet we put them into bodies of the action of which we know less), has not yet been fought to a finish. There have been two contributing factors on the side of progress—the remarkable growth of the skeptical spirit fostered by Paris, Vienna and Boston physicians, and, above all, the valuable lesson of homœopathy, the infinitesimals of which certainly could not do harm, and quite as certainly could not do good; yet

nobody has ever claimed that the mortality among homœopathic practitioners was greater than among those of the regular school." Of course he means those under homœopathic physicians, and not among the practitioners themselves; his syntax is as faulty as his argument. This is damning with faint praise with a vengeance, and perhaps is what the author intended. We do not know, neither do we care; but it is surely a false reading of history. When the author looks to a better knowledge of the action of drugs, does he forget that in the imperfect condensation of Hahnemann's homœopathy he has copied, as one of the principles, "The effects of remedies can be studied on the healthy only," and that this principle, as announced by Hahnemann and now universally recognized in scientific investigations, antedates any attempted improvement of the *materia medica* undertaken outside of homœopathy? From his standpoint of the sole duty of the physician to cure, and of symptoms as the only reliable indications of disease, Hahnemann's provings were, for his time and facilities, equally as scientific and much more practical than the elaborate scientific investigations of the present day in the same direction, conducted according to the principle first enunciated by him.

Again, any one who reads with an open understanding must recognize that Hahnemann's work contributed very much to the overthrow of the false theories of disease and its treatment prevalent in his day. The credit of his beneficent influence is not lessened by the fact that he set up a new theory in their place, since in its practical application it represented a decided advance in therapeutics.

That the homœopathic method, with its "bland dilutions" and "harmless and useless infinitesimals," most powerfully modified the heroic and murderous practices of Hahnemann's time, and that in our own day it has been a perpetual goad in the side of scientific pharmacy, spurring on to the production of "medicines that are palatable," is a fact which can hardly have escaped so close an observer as Dr. Osler. He should have given homœopathy credit for that positive side of its influence, and not have weakly sought to limit it to a negative recognition that cases sometimes recovered under homœopathic remedies equivalent to none at all.

It seems strange that the same individual who writes that

the infinitesimals of homœopathy could do no harm should have written, a little earlier in his article, "Strange as it may seem, the most typical of all infectious diseases—smallpox, scarlet fever, measles and hydrophobia—have as yet not yielded up their secrets. This is possibly due to the minute size of the micro-organisms concerned, which makes it beyond the power of the best microscope to demonstrate them." It would seem that there are some things capable of producing decided effects which are still too small to be demonstrable by the most powerful instruments at our command. Why should the infinitesimals of homœopathy be declared, *a priori*, to be inert? That's not logical, Dr. Osler. In short, we do not feel that the eminent author of "Medicine in the Nineteenth Century" has done justice to the influence exerted by homœopathy. By its mere existence it aroused certain activities which have been productive of great good throughout the whole realm of medicine, while in its own peculiar sphere it has shown a distinct advance, in that it has abandoned empiricism and is guided by law.

It is preëminently the science of therapeutics, and all regrets that no new discoveries in general scientific medicine emanate from homœopathic sources are uncalled for. These discoveries are outside of the province of homœopathy, although there is no good reason why they should not be made by homœopathic physicians. If they should be, homœopathy as such deserves no credit, nor does it merit blame if they should not be.

A MODERN DOGBERRY.

THE population of Philadelphia, both medical and lay—and with it probably every right-feeling person the country over—has recently received a severe shock, owing to a remarkable speech made by a Philadelphia judge. The circumstances attendant upon the case were as follows: A Dr. Moore, of Germantown (a suburb of Philadelphia), was subpoenaed to appear as a witness in court. On his way to the station he stopped to see a child seriously ill with diphtheria, and whose case would not permit of any delay. As a result, he missed his train, and

was half an hour late when he arrived in court. His honor proceeded to fine the doctor for contempt. On the following day the facts of the case were explained to the judge, who remitted the fine, and remarked that he had not been aware that the case was so serious. Had his honor stopped here he would have been applauded by every right-thinking member of the community, but he proceeded with the following remarkable utterance: "Still, it is better that a patient die, than contempt be shown for justice." This piece of wisdom came from a judge of whom it was remarked by a lawyer, at the time of his honor's election, "The bench is a means of honoring unsuccessful lawyers."

From the storm of indignation that has been aroused by the above unfortunate affair, good will no doubt arise. For years the medical profession has been put to great inconvenience and humanity made to suffer by reason of the exactions of legal martinets. The vast majority of lawyers are gentlemen in every sense of the term, and respect physicians not only as professional men, but for the good they do in the world. They are ever cognizant of humanity's demand for the physician's services, and they govern their court business accordingly. But unfortunately there is another class of lawyers—men who look only to their own convenience, are thoroughly selfish, and utterly oblivious of everything but their own whims. It is by such men as these that court attendance by physicians is made irksome.

The widespread discussion of Judge Wiltbank's unfortunate remark has elicited numerous comments by physicians and minor judiciary. The former have been aroused to a determination to remedy the inconveniences to which they have been subjected in the past by the small-fry of the bar, while magistrates and coroners have said their invariable practice is to consult the convenience of physicians when administering the affairs of justice.

As to judges in general, it has been our experience that, whenever they can possibly do so, they permit physicians to be examined out of the regular order, to save the physicians' time and to further the demands of humanity. It is unfortunate, therefore, that their honorable calling should have been stultified by the unjudicial remark of an unwise colleague.

GLEANINGS AND MEDICAL ABSTRACTS.

THE immensity of medical literature makes it impossible for any man, even though he is not the proverbially busy one, to study it entire. To overcome this difficulty numerous journals, and their number is unfortunately on the increase, have made it a feature of their publications to present weekly—we can just as truthfully say weakly—abstracts of the entire realm of periodical literature. The idea is at first sight attractive. But one does not perceive its fallacy until he has observed it in practice, especially on the part of magazines which formerly presented carefully selected and edited medical abstracts. The change, to our mind, is not a good one. In the desire to present a conspectus of everything, practically no subject is presented with the completeness of facts its importance warrants. The reader finds that his brain cannot grasp the multitudinous ideas; or, if he does grasp them, he does not retain. He longs for the old days when the individuality and experience of the editor and his ability to cater to the wants of the profession made the journal columns more valuable than they now are.

The reader is forced by the new movement into the position of the hotel guest who finds before him a *menu* card with ten or more soups, five or six fishes, and so on down the list, winding up with forty-two desserts, to say nothing of the wine list on the reverse side, for which he is invited to pay extra. If he is wise, he will make a careful selection. If he wants to take in everything he will taste of each article, and will probably arise from the table feeling that hunger has not been appeased.

Thus it is with omnivorous gleanings from medical literature.

THE TREATMENT OF EPIDERMOID CANCER BY THE X-RAYS.—Williams, of Boston, states that his experience at the Boston City Hospital indicates that we have, either in the X-rays themselves or in some other form of radiation from an excited Crookes's tube, a valuable therapeutic agent, and that the beneficent action of the X-rays can be brought about without causing a burn. Foul odors cease, the discharge becomes less, and the growth steadily diminishes in size. Details concerning the series of cases thus treated are promised.—*Boston Med. and Surg. Journ.*, Jan. 17, 1901.

GLEANINGS.

PNEUMONIA IN CHILDREN.—Tirard, opening a discussion before the British Medical Association, stated that in adults the typical course of pneumonia, its abrupt onset, the rise and course of the temperature, the altered pulse-respiration ratio, the expectoration, the altered physical signs, all lend themselves to a typical clinical picture; while the modifications are chiefly alterations in the lung area involved or individual peculiarities due to age, alcoholism, or the coexistence of another disease. Many suppose that most cases in children are broncho-pneumonias, attacking lobules but producing the characteristic physical signs of pneumonia. This is indeed most common in infants, and up to the second or even the third year, but after that the tendency to assume the adult type increases rapidly. The majority of cases seen in a children's hospital conform to the lobar type, the physical signs following closely the lobar outlines.—*Pediatrics*, Jan. 1, 1901.

F. Mortimer Lawrence, M.D.

THE CLINICAL VALUE OF THE HEART REFLEX.—Abrams, of San Francisco, writes at some length concerning the heart reflex. This can be observed only with the aid of the Röntgen rays, and consists in a contraction of the myocardium as the result of irritation of the skin in the precordial region by rubbing with a blunt instrument. The author believes that the success of the Schott method is simply the result of the cutaneous irritation provoked by the various manœuvres. As regards diagnosis, he considers the heart reflex test as pathognomonic and far exceeding all other methods yet recommended for differentiating a dilatation of the heart from pericardial effusion. If, in a given case of increased cardiac dulness, we vigorously rub the skin by means of a rubber and note after two minutes (the time necessary for the abolition of the lung reflex) a reduction in cardiac dulness, we are justified in concluding that we are dealing with cardiac dilatation and not with a pericardial effusion.—*Med. Record*, Jan. 5, 1901.

F. Mortimer Lawrence, M.D.

THE CAUSATION OF THE CONGENITAL STRIDOR OF INFANTS.—Thomson and Turner, in a communication to the British Medical Association, state their most important conclusions to be as follows:

1. That the primary element in the causation of this condition is a disturbance of the co-ordination of the respiratory movements, probably due to some developmental backwardness of the cortical structures which control them.

2. That the change of form found is merely an exaggeration of the normal infantile type, and is mainly if not entirely the result of a constantly recurring sucking-in of the upper aperture of the soft larynx, which is induced by the ill-co-ordinated and spasmodic nature of the breathing. That it is, in fact, an acquired deformity strictly analogous to pigeon breast.

3. That there is no proof that any congenital malformation of the upper laryngeal aperture exists in these cases.

4. That the supposition of a congenital deformity is not essential to account for the symptoms, inasmuch as normal babies crow in a very similar manner when they are coming out of chloroform.

5. That the sounds are not produced in the pharynx. This is proven by the high-pitched phonic character of the crow, and also by the fact that the stridor persists, not only when the nostrils are closed, but equally when the mouth is occluded by the nipple, when the tongue is depressed by a spatula, and during yawning. That they are not produced in the trachea by compression exerted by a large thymus or enlarged lymphatic glands we conclude on two grounds: first, because in none of the fatal cases have we seen such enlargement; and, secondly, because in two cases in which compression of the trachea by enlarged bronchial glands was found after death, the symptoms were of a very different type.

6. That the neurosis causing the symptoms has not in our experience seemed to depend on the presence of adenoid growths or other obvious causes of reflex irritation.—*Pediatrics*, Jan. 1, 1901.

F. Mortimer Lawrence, M.D.

PYELONEPHRITIS IN CHILDREN.—Fischer, of New York, reports the case of a child, aged twelve and a half years, who suffered with fever, chills and constant abdominal pains, mostly in the right hypochondriac and iliac regions. A large tumor was seen and easily felt on the right side of the abdomen. The urine was examined many times, and large quantities of albumin, casts and blood were found; but at no time could pus be discovered. This rendered the diagnosis very difficult, but as the tumor completely involved the region of the right kidney he advised operation. The tumor was found to be of renal origin, the pelvis forming a large pus sac, while the kidney proper was the seat of numerous small abscesses, undoubtedly due to extension of the process from the pelvis; and there was a chronic interstitial nephritis. Complete recovery followed the nephrectomy.

In this connection the author refers to the elaborate review of this subject by Baginsky in the *Archiv für Kinderheilkunde* (Band xxii., p. 232), and states that in studying the latter's cases as well as his own the following points are noteworthy:

1. That this disease is characterized by the presence of severe gastro-dyspeptic symptoms, such as anorexia and vomiting, pain in the region of the kidneys, and the long continuance of these symptoms.

2. Constipation. In Baginsky's cases there was shedding of large pieces of membrane, mingled with hardened fecal masses.

3. The variability of the urine, changing from a perfectly healthy specimen to one containing large quantities of albumin, pus, morphotic elements and mucus.

4. The peculiar type of fever, intermittent in character, with chills and general malaise—in his own case accompanied by a gradual but constant emaciation.

5. That the urine in cases of pyelonephritis shows, according to Baginsky, the presence of the bacterium coli in pure culture.—*Archives of Pediatrics*, January, 1901.

F. Mortimer Lawrence, M.D.

THE SYMPTOMS OF LEUCOCYTHEMIA.—Saundby, of Birmingham, in the course of a clinical lecture, refers to the somewhat curious fact that the first symptom of which these patients complain seems to depend upon enlargement of the liver. We should naturally expect weakness, shortness of breath or other consequences of anæmia to attract attention at an earlier date; but in six cases described, three complained of swelling of the abdomen and three of pain in the left side, the other symptoms being secondary. This is fortunate, for it makes it much less likely that the enlargement of the spleen will be overlooked; and once this has been discovered no one who is acquainted with the existence of leukæmia will neglect to make a microscopical examination of the blood. For ordinary diagnosis it is quite sufficient to obtain a drop of blood by pricking the finger and examining it under a magnifying power of 300 to 400 diameters, when the enormous increase of leucocytes can be recognized readily.

As is usually the case in diseases of the blood, the action of the heart becomes extremely feeble; the pulse is increased in frequency, soft and weak; the apex beat becomes diffused; a systolic murmur replaces or accompanies the first sounds, and a venous hum may be heard over the vessels in the neck. Thrombosis is apt to occur, owing to the excessive number of white corpuscles, and this in turn becomes a cause of hæmorrhage. Epistaxis and bleeding from the gums, melæna, hæmaturia and retinal hæmorrhage are all liable to occur. Digestive disturbances are exceedingly common. In acute cases fever may be present, and its occurrence argues in favor of a possible infective origin of the disease, although inoculations with leukæmic blood have been without result.—*Brit. Med. Journ.*, January 5, 1901.

F. Mortimer Lawrence, M.D.

THE DISINFECTION OF TYPHOID URINES.—Gwyn, of Philadelphia, concludes that:

1. In from 20 per cent. to 30 per cent. of cases of typhoid fever typhoid bacilli may be present in the urine.

2. When present they are usually in pure culture, and may be so numerous that the urine is turbid when freshly voided, one of Petruschky's cases showing 170,000,000 bacilli in 1 ccm. of urine; one of the writer's own showing 500,000,000 per ccm.

3. Appearing generally in the second and third week of illness, the organisms may persist for months or years. In Houston's case the bacilli had been for three years in the bladder, and in one of the writer's cases bacilli were found in the bladder three and five years subsequent to the attack of typhoid fever.

4. Though often showing evidence of cystitis and marked renal involvement, the urine containing bacilli has usually the characteristics of a simple febrile urine; the presence of the bacilli has no prognostic significance, and they may persist for some time without causing local change, multiplying in the urine which remains perfectly acid.

As a result of investigations as to the minimum amount of disinfectant necessary for complete disinfection in the shortest time, it was found that milk of lime was neither rapid nor certain—of the ordinary hospital solution 10 c.c. required four hours to disinfect 10 c.c. of urine; carbolic acid was effective only in strong solution and large amounts; bichloride of mercury was both

powerful and rapid, its presence in a proportion of from 1-5000 to 1-40,000 completing disinfection in one hour; formalin was efficient, but expensive; while chlorinated lime and liquid chlorides were rapid and efficient in comparatively dilute solutions.—*Phila. Med. Journ.*, January 12, 1901.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF PNEUMONIA.—At a meeting of the Clinical Society of Maryland, Brown called attention to the four-fold tendency of the work in this line during the past year, viz.: first, the growing tendency in favor of hydro-therapeutic measures; second, against the systematic use of drugs of any kind; third, the greater attention to prophylactic measures; and fourth, the holding out of a greater semblance of hope that in the near future an effective method for directly controlling the toxæmia may be found in an antitoxic serum.

Osler, in the ensuing discussion, expressed his deepening pessimism as to the outlook for these patients. We have gotten rid of the high mortality rate in diphtheria, in typhoid, in scarlet fever and measles; in fact, all the eruptive diseases, combined with their complications, do not kill as many people annually as pneumonia alone. There are fewer mistakes in the mortality records of pneumonia than in any other disease; it kills quickly and promptly. What we are to do against it is the question. He is convinced of one thing—that in the rigid, thorough and systematic hygienic treatment we have the best grounds for hope of a slight reduction in the mortality of this disease. He has used those measures heretofore that gave the best mortality record according to the statistics collected by May; but his pneumonia statistics are equally as remarkable—all of the cases have been treated faithfully with ice-bags, and the mortality record statistics are the same to the very figures, viz., 25 per cent. of the cases died. Of course many physicians have a lower rate in private practice. He hesitates to tub all cases, whereas he thinks that we can give effective sponging to practically all. The cold sponge should be thoroughly given, and it is not far behind the cold bath in general unpleasantness and good effects. The use of saline infusion often helps to support and tide over a weak heart; but as to the value of oxygen he is doubtful. What we need to-day is a careful study of a large number of cases seen in private practice, where better opportunities exist for seeing and observing them.—*Virg. Med. Semi-Monthly*, January 11, 1901.

F. Mortimer Lawrence, M.D.

THE CLINICAL SIGNIFICANCE OF DULNESS IN APPENDICITIS.—Miller, of Springfield, Ohio, believes that sufficient stress has not been placed upon the "point of dulness" in the appendical region, and states that he is disposed to wait for the actual formation of an inflammatory exudate, detectable as dulness, before attempting operative interference. In every instance in his experience in which he has relied upon this symptom he has been led to a correct conclusion. In support of his contention he reports nineteen cases. In every instance in which dulness was present pus was diagnosed, and this was verified by either an operation or a post-mortem examination, with the exception of two cases. In one of the latter the presence of peritonitis with a general septic infection insured a correct diagnosis; while in the other case operation was refused, but recovery followed the discharge of the pus through the bowel.—*Med. Record*, February 9, 1901.

F. Mortimer Lawrence, M.D.

REMOVAL OF PELVIC INFLAMMATORY MASSES.—(Kelly.)—After opening the abdominal cavity, if the uterus is buried out of view, the bladder is first separated from the rectum and the fundus found; then, if there are any large abscesses, adherent cysts, or hæmatoma, they are evacuated by aspiration or by puncture; the rest of the abdominal cavity is then well packed off from the pelvis.

The right and left cornua uteri are each seized by a stout pair of museau forceps and lifted up; the uterus is now incised in the median line in an antero-posterior direction, and as the uterus is bisected its cornua are pulled up and drawn apart. With a pair of forceps the uterus is grasped on one side on its cut surface, as far down in the angle as possible, including both anterior and posterior walls. The museau forceps of the same side is then released and used for grasping the corresponding point on the opposite cut surface, when the remaining museau forceps is removed. In this way two forceps are in constant use at the lowest point. He commonly applies them three or four times in all. As the uterus is pulled up and the halves become everted, it is bisected further down into the cervix; if the operator prefers to do a panhysterectomy, the bisection is carried all the way down into the vagina. The uterine canal must be followed in the bisection, if necessary using a grooved director to keep it in view. The museau forceps are now made to grasp the uterus well down in the cervical portion, if it is to be a supravaginal amputation, and the cervix is bisected on one side. As soon as it is divided, and the uterine and vaginal ends begin to pull apart, the under surface of the uterine end is caught with a pair of forceps and pulled up, and the uterine vessels, which can now be plainly seen, are clamped or tied. As the uterus is pulled still further up, the round ligament is exposed and clamped, then finally a clamp is applied between the cornua of the bisected uterus and the tubo-ovarian mass, and one-half of the uterus is removed. The opposite half of the uterus is taken away in the same manner.

The pelvis now contains nothing but rectum and bladder, with right and left tubo-ovarian masses plastered to the sides of the pelvis and the broad ligaments, affording abundant room for investigation of their attachments, as well as for deliberate and skillful bisection; the wide exposure of the cellular area over the median and anterior surfaces of the masses offers the best possible avenue for beginning their detachment and enucleation. Sometimes the half of the uterus can be removed with the corresponding tube and ovary to advantage.

The most critical point in the operation is the bisection of the cervix and controlling the uterine vessels; if the cervix is slowly and cautiously severed, with a steady traction on the uterus under perfect control, there is no danger of seeing the organ suddenly tearing out with rupture of the uterine vessels and frightful hæmorrhage. As the divided cervix is pulled apart, the uterine vessels are beautifully exposed and easily caught.—*American Journal of Obstetrics*, December, 1900.

George R. Southwick, M.D.

OPERATIVE TREATMENT OF CANCER OF THE UTERUS IN RUSSIA.—(Von Ott.)—The operation of choice is vaginal extirpation with an average of 10.3 per cent. mortality, though some surgeons have a much more satisfactory rate. In 250 cases from whom reports could be obtained, five or more years after the radical operation, there were 30 free from recurrence, and divided as

follows: 5 years, no recurrence, 13 cases; 6 years, no recurrence, 6 cases; 7 years, no recurrence, 3 cases; 8 years, no recurrence, 1 case; 9 years, no recurrence, 3 cases; 10 years, no recurrence, 4 cases.

Ott has had better results. In 189 cases, on which he had operated up to April, 1894, *i.e.*; 6 years, 62 have remained perfectly well. It is interesting to note that adeno-carcinoma admitted twice as favorable prognosis regarding recurrence as cancer of the neck of the uterus.

The radical operation in his clinic is performed whenever there is reasonable hope of completing the operation. Sometimes cases which are seemingly hopeless live for a number of years without recurrence. This shows that the prognosis is not governed by the mere progress of the disease. An early microscopic examination is of the utmost value.—*Monatsschrift für Geburtshilfe u. Gynäkologie*, September, 1900.

George R. Southwick, M.D.

THE TREATMENT OF PREGNANCY AND LABOR COMPLICATED BY MYOMA OF THE UTERUS.—(Pobedinsky.)—Interference during pregnancy is not warranted except when dangerous symptoms are present. Even when myoma are situated low down, the possibility or impossibility of giving birth to the child cannot be determined during pregnancy, as towards the end of pregnancy, and even during labor, the myoma may be drawn back above the brim and offer no obstacle to the progress of labor. The best method is myomectomy, preferably by vagina, and preserving gestation. When it is impossible to remove the tumor only, the entire pregnant uterus must be removed, after first performing Cæsarian section if the fœtus is viable. In operating during labor remove the tumor, if possible, by the vagina. If the tumor is inserted high up and a portion of it projects into the small pelvis, try to push up the tumor, aided by narcosis if necessary. If vaginal myomectomy is not possible, reposition is not successful, and the child cannot be delivered without great danger to its life by some obstetrical operation, then Cæsarian section finds its so-called relative indications and is justifiable. In abdominal laparotomy the tumor should be removed and the unopened uterus preserved, but if Cæsarian section be performed the uterus must be removed with the tumor.—*Monatsschrift für Geburtshilfe u. Gynäkologie*, September, 1900.

George R. Southwick, M.D.

THE TREATMENT OF RUPTURE OF THE UTERUS.—(Schmit.)—Incomplete ruptures are treated by gauze packing and drainage with a mortality of only 28.57 per cent. in Schanta's clinic in Vienna.

Complete ruptures of the uterus are far more dangerous than incomplete, and the danger lies very largely in infection of the peritoneum. Death from anæmia is rare. Large ruptures must be treated by laparotomy and show a mortality of 50 per cent.; but unless the rupture is very extensive should be treated by drainage, which shows a mortality of only 38.46 per cent.

The less the peritoneum is handled and the more perfect the drainage, the better are the results. Iodoform gauze is the best material, and is used for drainage and not as a tampon to arrest hæmorrhages, as Fritsch has shown that such a tampon may be the direct cause of a new hæmorrhage. This method of treatment also shows better results than pure expectancy. No disadvantages from its use have been observed. The strips of gauze are removed on the eighth day.—*Monatsschrift für Geburtshilfe und Gynäkologie*, September, 1900.

George R. Southwick, M.D.

THE THEORIES OF ACCOMMODATION.—The author presents the theory of Carmona y Valle, comparing it with those of Helmholtz and Tscherning. Briefly stated, this theory is that the act of accommodation is accomplished by a compression of the periphery of the crystalline lens through the action of the circular fibres of the ciliary muscle. This compression, acting upon the anterior fibres of the zonule, squeezes the soft portion of the lens, crowding it towards the centre and producing a thickening of that part. As the lens is supported posteriorly by the vitreous humor the anterior surface comes forward. By drawing the choroid forward the radial longitudinal fibres of the ciliary body assist in maintaining the position of the posterior surface of the lens. A lenticonus is thus formed. The slow recession of this lenticonus produces the phenomenon previously observed. The writer believes that if the accommodative act was produced by a recession of the lens, the descent would be rapid and uniform, instead of by a series of movements, as is really the case.—M. Uribe, Troncoso, Mexico (*Annals d' Oculistique*).

William Spencer, M.D.

SUDDEN CHANGES IN OCULAR REFRACTION IN DIABETES.—Sourdille reports a case of a man who, suffering from diabetes, suddenly noticed a failure in vision. While studying the refraction it was found that he had two diopeters of hypermetropia, and that the correction of this brought the vision from one-sixth to full acuity. The diabetes was successfully treated in so far as the amount of urine excreted was concerned, and the hypermetropia disappeared. During the hypermetropic period tension was slightly below normal, but this condition disappeared with the disappearance of the hypermetropia. The author feels that the least improbable theory in regard to the causation of these sudden refractive changes is an abstraction of fluids from the vitreous chamber, the fluid being replaced by blood which is overladen with sugar.—Sourdille, Nantes (*Le clinique ophthalmologique*).

William Spencer, M.D.

THE BACTERIOLOGY OF THE NORMAL NOSE.—Until 1895 it was taken for granted that the normal nares were teeming with bacteria. Within the last five years this opinion has entirely changed. The cause of this freedom of the nose proper (that portion posterior to the vestibules) is probably three-fold, to wit: (a) the motion of the ciliated epithelium; (b) inhibitory action of the mucus, and (c) the phagocytosis of the leucocytes.

The author draws the following conclusions: "Considering the large quantity of dust-laden and germ-carrying air which passes hourly into the nasal fossæ, they are remarkably free from micro-organisms. Certain authors have always been able to find some organisms in the healthy nose, though always in small numbers; other have found none in a majority of cases. This difference is probably due to the fact that the latter observers simply lifted loops of mucus from one spot, while the former generally swept out the nose with pledgets of sterilized wool.

"All researches have confirmed the observation that the vestibules of the nose swarm with organisms. Previous observers have demonstrated the action of the ciliated epithelium in sweeping out intruding matters from the nose, and the effect of the trickling of mucus in cleansing the mucus surfaces. Wurtz, Lermoyes and Praget claim decided bactericidal power for nasal

mucus. Others (Thomson and Hewlett) have not been able to do more than prove that the mucus has an inhibitory effect on the development of micro-organisms, while some, again, have only formed the conclusion that mucus is not a favorable medium for their development. Phagocytosis shares in the work of removal, and for a study of this side of the question the thesis of Dr. Violet is interesting and instructive."—St. Clair Thompson, M.D. (London), *Jour. Lar. Rhin. and Otol.*

William Spencer, M.D.

ARE DILATED PUPILS INDICATIVE OF A PRETUBERCULAR STAGE?—Dr. Thos. F. Harrington, of Lowell, Mass., maintains that habitually dilated pupils signify a pretubercular condition, and says that those so affected are quite sure to end in full-fledged tuberculosis unless this is guarded against by the usual hygienic, dietetic and medicinal measures. If this claim is correct, it is a matter of prime importance that it should be universally known. As the author says, no harm can result from the needless care an individual would get in the effort to ward off a non-existent disease, to which, however, we feel constrained to add the proviso, except the harm done by fright in those sure to be so affected. We hope that our readers will take up this matter, and watch all the cases having constantly dilated pupils without assignable cause.—*The Medical Council.*

William Spencer, M.D.

INFANTILE COLIC.—This is due to an irregular peristalsis mainly of the small intestine, accomplished with such violence as to cause a compression of the nerve filaments. This peristalsis is not necessarily attended with fecal discharge.

The causes are placed under the following heads: (a) Flatulence. (b) Influences acting through the mother. (c) Indigestion. (d) Refrigeration.

Flatulence is by far the most important cause. The intestinal tract has not yet reached its normal degree of efficiency, and the digestion is not accomplished with speed, therefore an undue collection of gas is allowed to take place and distend the bowel. Again, sufficient secretions are not present to complete the digestion. Constipation in the mother with resulting constipation in the child is another frequent cause of colic. If the diet of the mother be of such a nature as to cause flatulency in herself, then that condition is readily developed in the child. The use of cathartics and of foods containing an excess of acids are a most frequent cause of colic. Mental state of the mother, such as fits of anger, worry, and the depression caused by paroxysmal pain, are all shown to play an important part in the production of colic in the infants.

Perhaps the most common error in diet to produce *indigestion* is the excessive feeding of the child. The effort of the bowel to unload itself is said to be the cause of nine-tenths of the pain. The child may not be fed too frequently, but the amount given at one time may be entirely too large for its age.

By refrigeration is meant the chilling of the body by exposure or by cold foods. The swallowing of air through the nipple and tubes given to the child to pacify it, by which it is claimed that the air sucked in and swallowed results in an attack of colic.—*Philada. Med. Journ.*, February 2, 1901.

William F. Baker, A.M., M.D.

IMPORTANCE OF A KNOWLEDGE OF EAR DISEASE TO THE GENERAL PRACTITIONER.—The general practitioner is cautioned about the little thought that is usually given to "discharging ears." Several cases are cited in which purely emotional disturbances are mistaken for hysteria which were dependent on serious intra-cranial lesion from ear disease. The suggestion is offered that any marked depression of spirits, with frequent weeping accompanying persistent headaches, in patients who have ear disease, should put the practitioner on his guard and lead him to ask about chilliness, to watch the temperature, note pulse, especially to recognize any settled expression of anxiety which to the practiced observer is very distinct from the whining hysteria.

The presence of intra-cranial organized exudates is made known early by what is called "myoclonus." This consists of muscular twitchings in different parts of the body, notably the extremities, especially when the patient is going to sleep. The cortical irritation may be so marked as to lead to an epilepsy.

Another important symptom is vertigo, where there is a feeling of alarm coming on when the patient is recumbent.—*N. Y. Med. Journal*.

William F. Baker, A. M., M. D.

TYPHOID PLEURISY.—The relation of certain cases of pleurisy to the typhoid bacillus has been pointed out recently. The bacillus has been isolated and pure cultures grown from the fluid of an empyema following typhoid fever. A case is reported in which there was a pleurisy following a typical attack of typhoid.

The results of the bacteriological examination of the pus drawn from the chest were as follows:

On the media the various cultures presented the following reactions:

Agar-agar: Moderately abundant, moist, grayish-white growth, no discoloration of the medium.

Gelatin stab: Growth along the entire line of inoculation. No liquefaction.

Litmus milk: Slight acid fermentation at the end of 3 days. No coagulation of the milk in 14 days.

Potato: Moderate, glistening gray, moist growth along the inoculation tract. No odor.

Bacteriological diagnosis: *Bacillus typhosus* in pure culture.—*Amer. Journ. Med. Sciences*, Jan., 1901.

William F. Baker, A. M., M. D.

A CLINICAL STUDY OF DIPHTHERIA.—Report of 2093 cases. After discussing the general mortality of diphtheria before the introduction of antitoxin, the fact is made plain by statistics that the mortality has been lowered materially since the introduction of the antitoxin.

Age and Sex.—Majority of cases occur under 15 years of age, although they may be found in persons from 6 weeks to 68 years. Females seem to be affected most.

Mortality Rate.—There is a decreasing rate from infancy to adult life. From 1 to 15 years the percentage was 14, and from 15 years up, 2.85 per cent.

Distribution of the membrane, tonsil, post-pharyngeal wall, nose, larynx,

denuded skin area: In the majority of cases it was situated on both tonsils. The membrane is an important guide as to the local process, but it is not to be relied on as forming an index of the consequent toxæmia.

Disappearance of the Membrane.—It may peel off, roll up on the edge, or it may disappear in streaks and leave remaining streaks even after the antitoxin has been used.

There were only 71 cases of *nasal* diphtheria, but 780 had a nasal discharge that would suggest it.

Cultures.—Bacilli were found in most cases, but in those cases that gave negative results the disease ran a virulent course. This was explained by saying that the bacilli on the membrane were dead, but not until the mucous membrane was reached did the bacilli take in culture. A clinical diagnosis is possible, and one should not be justified in awaiting entirely for the results of the culture.

Heart.—Sixty-five per cent. had some form of cardiac disturbance. A soft systolic murmur was the most heard, loudest at the apex in the mitral area. This seemed to be due in some cases to dilatation, or active inflammation in the endocardium. The most frequent observation was the extreme weakness and lack of tonicity of the heart-muscle. The heart condition changed frequently, and the arrhythmia was well marked. Heart complications occurred more frequently in nasal diphtheria, due probably to a more abundant supply of lymphatics in the naso-pharynx, through which absorption of the toxins took place.

Pulse, Rapid.—This is a diagnostic point in the initial stage of the disease. The rapidity is out of all proportion to the severity of the initial symptoms. If, in the course of the convalescence, after the use of the antitoxin, the pulse becomes rapid, although the patient may feel comfortable, it is a dangerous sign. A continuous rapid pulse after the initial rise is to be followed by a guarded prognosis.

Albuminuria.—The free use of antitoxin has lessened the amount of albumin, for those treated early and with sufficient doses did not show albumin at any time.

Laryngeal stenosis was found in 337 cases, of which 213 were intubated. Several entire casts of the trachea were coughed up, showing the rapidity with which the membrane can spread in the air-passages.

Complications.—Glandular enlargements, otitis media, paralysis.

Vomiting was found as an initial symptom in twenty-seven per cent. of cases. Occurring in the course of convalescence, it means nerve degeneration. Vomiting in a patient whose heart is weak and irregular, and who presents other evidence of degeneration, is the beginning of the end.

Middle ear disease was not a frequent complication. The bacillus diphtheria was found in the discharges of 6 cases.

Nerve Lesions.—The damage to the nerves is not always in proportion to the severity of the symptoms. The most common paralyses were palatal. One case of hemiplegia was reported. Among the others were ocular palsies.

Mixed Infection.—Several cases are mentioned which are undoubtedly ones of diphtheria and scarlet fever, and in these cases the death-rate is high.

Treatment.—The recovery depends, in most cases, on the early and sufficient administration of the antitoxin. There is no danger in giving too much.—*Amer. Journal Medical Sciences*, Feb., 1901.

William F. Baker, A.M., M.D.

ABSCESS OF THE CEREBELLUM.—In speaking of cerebellar abscess M. Dieulafoy says, in substance: With a few exceptions, abscesses of the cerebellum are secondary to an otitis. Whether the otitis is acute or chronic, whether it is accompanied by a discharge or not, is of little importance; the moment the cavity of the tympanum becomes infected, the pathogenic agents force their way toward the confined cavities which have for their seat the cavity of the tympanum, the mastoid cells. From there they spread in different directions. The intracranial lesions consecutive to otitis are many: cerebral meningitis, cerebro-spinal meningitis, pachymeningitis, phlebitis and thrombosis of the sinuses, abscess of the cerebrum and cerebellum. Abscess of the cerebellum generally produces the true cerebellar syndromes, pain predominating in occiput, vertigo, loss of equilibrium, staggering gait, vomiting, nystagmus, cervical contracture, optic neuritis, muscular asthenia, a state of somnolence and torpor bordering on coma. The symptoms composing the cerebellar group in their true form can exist, no matter which part of the cerebellum is involved, whether it be the right, left or middle lobe. The paralysis of the external oculo-motor nerve permits of the localization of the lesion in one of the lobes of the cerebellum. The diagnosis of cerebellar abscess presents some difficulty. The symptoms have many great analogies with auricular and labyrinthine disease. The pain originating from the labyrinth has not the violence, the persistence, nor the location of the cerebellar pain; the somnolence and torpor which become daily aggravated in cerebellar abscess have no comparison in the symptoms arising from the labyrinth. Cerebellar abscess must be distinguished from abscess of the cerebrum (temporo sphenoidal and occipital lobes). In case of cerebral abscess, the motor troubles, the paresis, contractions, spasms, are seated in the opposite side to the lesion or the otitis. The word-blindness and hemianopsia are important signs. Tumors of the cerebellum, glioma, glio-sarcoma, tubercular and parasitic tumors, also produce cerebellar symptoms, but the symptoms are rarely in a pure state, because the tumors, by their extension and pressure, produce the symptom of the surrounding structures. Syphilis of the cerebellum occupies an important place here from the point of diagnosis and treatment. Surgical intervention at the proper time is the only treatment applicable to abscess of the cerebellum.—Report of the French Academy of Medicine in *Le Progrès Medical*.

John J. Tuller, M.D.

GNORRHŒAL PERITONITIS.—In a recent issue of *Le Progrès Medical* Dr. Leon Lebovici, of Carlsbad, reviews a paper read before the Society of Internal Medicine, of Berlin, by Prof. Leyden, on "Gonorrhœal Peritonitis."

It was in 1893 that Prof. Leyden demonstrated the presence of gonococci in endocarditis, which was afterwards confirmed by other observers. Since that time gonococci have been found in several different diseases, particularly in the gonorrhœal arthritides. Several cases of peritonitis have been reported, two among them being Americans, in which the cause was recognized to be gonorrhœal; but in none of these cases, the reviewer says, was the proof furnished by the culture. In Prof. Leyden's case the proof of the etiology was

made absolute by the pure cultures. The case, a woman, 29 years of age, was admitted to Prof. Leyden's clinic in Berlin with a high fever, associated with ascites,—the period of onset not being exactly known. The patient was in a wretched condition. She had been pregnant two years before, had suffered an attack of jaundice, and had aborted. Afterward the abdomen began to swell, and the patient complained of urinary disturbance, but the examination of the urine revealed nothing. The abdomen was tapped and the liquid removed. The liver was found to be hardened but not hypertrophied; no tumors were found in the abdominal cavity. The patient's temperature was constantly elevated, at times reaching 39.6° C. No pneumonic trouble. The temperature continued to rise, vomiting set in, and the patient died. The autopsy showed a contracted granulated liver, an extensive interstitial hepatitis, and a tumefied spleen. The liquid in the abdomen was found in copious quantity and purulent. The liver and intestines were found to be covered with a thick fibrinous exudate. The most careful bacteriological examinations were made, disclosing the presence of the gonococci, they having been constantly nourished by the abdominal fluid.

John J. Tuller, M.D.

HYSTERIC SIGHING, ROARING AND ERUCTATING.—Prof. Grocco, of Florence, Italy, reports in detail four interesting cases.

The first was a woman of twenty-seven, with nervous antecedents and hysterical precedents, who had a maternal aunt who had suffered from a barking cough, probably of hysterical origin. After a mental shock she was seized with a respiratory orgasm which caused her to emit inarticulate cries, which later changed to sighing, which soon increased with such frequency that it was actually frightful. The least noise, or the sight of a member of her family, or even the sound of music, would aggravate her. Continuing thus for four months, during which various remedies and measures were tried in vain, a member of her family falling ill, she seemed cured for a week, but the cure was not lasting. Entering the hospital, the objective signs of hysteria were: a notable reduction of the acuteness of vision and of the visual field, especially in the left eye, pain in the epigastrium and left ovary, abolition of the pharyngeal reflex, etc.

After preliminary suggestive treatment, the electro-static bath and breeze were employed, which caused her symptoms to disappear in four or five days as if by enchantment. Neither the sight of her relatives, sudden noises, emotion or music would cause them to recur. Returning home, she had a relapse in a month or so, which was treated successfully by seven electrostatic treatments.

The second case was that of a woman of nineteen, who was a friend of and took care of the preceding patient. She had been much impressed by her sufferings. She had been exposed to a number of mental shocks, and was chloro-anæmic, with an incipient tuberculosis of the apex of the one lung. She would raise her upper lip, dilate her nostrils, and drawing in her lower lip emit a singular cry, which might be likened to the roar of a wild animal. She was also aphonic. Treated like the preceding, she recovered, only to relapse after having heard that she was tuberculous. Restored to health again, she died a few months later of acute miliary tuberculosis.

The third, a sister of the second patient, suffered from hysteric sighing,

which increased so rapidly that from eight to ten sighs would be noted in a minute. The same treatment was successfully used in her case.

The fourth case was a woman of forty-four years, without neuropathic antecedents, but with hysteric stigmata, and who, suffering from vague gastric symptoms, had six months before coming under observation commenced to be afflicted with sighing, especially after meals. At first there would be only two or three, but the attacks gradually increased in number until they reached one to two hundred a day. Finally, as many as one hundred in half an hour were noticed; some one of her friends had counted even thirty-five in a minute. Her friends were very much alarmed. Three months after being seized she began to swallow a certain quantity of air, which she would belch during and after each sigh. After several eructations she would emit a longer and louder ructus. Hysterical stigmata were quite prominent, and though electrostatic treatment was tried, it was with only partial success.—*La Rivista Critica di Clinica Medica*, No. 1, 1901.

Frank H. Pritchard, M.D.

A SALVE FOR ECZEMA OF CHILDREN.—Prof. Leistikow, in dry and not too severe forms of papular and vesicular eczema, recommends a paste of lard, zinc oxide, starch, aa 5.0, yellow vaseline 10.0, yellow oxide of mercury 0.25–0.5. In continually recurring and intensely itching eczemas of children he has had very good results with pyrogallie acid. It has rarely failed him; yet a small dose is necessary, and a careful watching of the urine is advisable. A one-half to one or even a two per cent. ointment is best employed. The influence on the itching is decided. At times reddening of the skin will be caused by the treatment, which may require other measures.—*Muenchener Medicinische Wochenschrift*, No. 3, 1901.

Frank H. Pritchard, M.D.

EYE SYMPTOMS AFTER THE USE OF THYROID PREPARATIONS.—Dr. H. Coppez, of Brussels, reports observing five cases, of which four were women, in whom a prolonged use of the thyroid preparations brought about very serious optic neuritis, with associated lesions of the disc, which were more pronounced than in poisoning from tobacco or alcohol. The amblyopia was noted only after the remedy had been taken for several months, but when once under way, the disease so rapidly developed that in six weeks to two months the vision fell to one-tenth or still lower. In general, leaving off the drug was sufficient to cause the trouble to become stationary, decrease, and finally to disappear altogether. But whenever the retinal vessels are affected one should treat the patient energetically with local blood-letting, the internal use of nux vomica and the continuous current. Curiously enough, these patients did not present the usual signs of thyroid intoxication; therefore, it is well to know that this form of poisoning may only manifest itself by a retro-bulbar optic neuritis with a central scotoma. Hence, if a patient have these symptoms, which may be due to one or another of the thyroid preparations, now so popular in the treatment of obesity, one should inquire particularly whether he has been taking any of them. Another Belgian physician, Dr. Venneman, in two young girls has noticed an accommodative asthenopia follow the use of tablets of thyroid extract. Once left off, the ocular disturbance did not continue long.—*La Semaine Medicale*, No. 4, 1901.

Frank H. Pritchard, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

DISEASES OF THE MAMMARY GLAND—MEDICAL TREATMENT. HOMŒOPATHIC AND PALLIATIVE.—Dr. E. Stillman Bailey says that all cases of mammary tumors should receive at the first moment of their discovery careful consideration from a medical standpoint. Failure to recognize the character of the enlargement may condemn the patient to other methods of cure later on. He further states that while the totality of the symptoms offers the only principle in the selection of the remedy, a far greater symptomatology is possible when coupled with an intimate knowledge of the pathology. The writer believes that the suppression of abnormal uterine discharges, the sudden checking of a vicious leucorrhœa, or the suppression of skin eruptions, may result in mammary enlargements. From his remarks upon the following remedies we have condensed these indications.

Sulphur.—The sensation of *burning* is a valuable and reliable indication for this remedy. The skin or nipples burn like fire, or the parts are hot and tender, or the itching or an eruption causes burning. A history of previous skin disease, suppressed eruptions, or the ill-advised suppression of an infective leucorrhœa. Under such circumstances the writer thinks that the exhibition of sulphur will often bring about a cure.

Psorinum.—In the chronic neoplasms, such as have proven that they continue to be innocent and which do not increase in size, sulphur, psorinum and calcarea constitute a trinity to be remembered. These remedies should be given in the higher dilutions.

Thyroidine.—Diseased mammary glands connected with a diseased uterus, preferably of fibroid character or cases of fibroid hardening. Fibroid hardening of the cellular tissues of the breast, with fibroids of uterus, is an ideal indication. The patient may complain of weakness and hunger, and may lose flesh though plenty of food is taken. Soreness of the mammæ. Palpitation of the heart on least exertion. Stony hardness of glands in groin or in axilla. Uterine hæmorrhages are irregularly profuse. No heat or fever or redness of affected breast. The writer has used this remedy in the first decimal trituration during the past four years, and speaks of its salutary effects when prescribed upon these indications.

Phytolacca.—The breasts are very hard, greatly swollen and very painful; fever, heat, redness, and tendency to suppuration seems impending. In innocent neoplasms he considers the phytolacca a very efficacious remedy. In mastitis it is useful even during the suppurative stage.

Belladonna.—Redness in streaks or universal redness and throbbing. For the acute cases when the first hardness is noticed. The writer thinks that perhaps belladonna has aborted more mammary neoplasms than any other one remedy.

Arnica.—Tumors from bruises. Soreness, discoloration and bruises. Clothing, bed and bandages all aggravate the soreness.

In addition to these remedial measures, the writer recommends support of the affected breast by bandages, the external application of *arnica*, *hamamelis*, *calendula* or *phytolacca* cerates, or the same remedies applied locally upon soft cottons, gauzes or lint.—*The Clinique*, January 15, 1901.

(In our humble opinion, the advice of a conservative surgeon will prove of much value to both patient and to his medical adviser, especially in the *early* stages of mammary neoplasms.)

O. S. Haines, M.D.

CHOREA CURED BY TARENTULA CUB. 6.—A girl 12 years of age had suffered from violent chorea for two years, dating from a severe fall by which her arms had been injured. The movements were worse in the upper parts of the body, and continued even during sleep. Complained of headache and weakness, and was easily exhausted. Slept best towards morning. Fat meat disagreed. Heart-sounds normal.

The first prescription was *puls.* 30, under which her headache left and her general condition improved, although the choreic movements continued. She then received *caust.* 2, two drops three times a day. At the end of a week reported continued improvement. The movements were now confined to the left side, and occurred principally at night. *Tarentula cubensis* 6, one dose four times a day, was given. Under the continued use of this remedy a complete cure resulted in five months—not too long a time, considering the two years during which the illness had lasted and the inefficacy of all other methods of treatment.—*Hom. Monatsblätter*, December, 1900.

MEDICAL TREATMENT OF DIPHTHERIA.—Notwithstanding the very generally accepted belief in the specific powers of diphtheria antitoxin, there are still, at the present time, many physicians who think that medicinal therapeutics should have an important place in the treatment of this grave disease. Dr. Charles Bruce Kern, in the January number of the *Homœopathic Journal of Obstetrics*, thinks that some of our remedies will also produce specific curative effects in the carefully individualized case. He thinks that some form of mercury should probably stand first, as the nearest simillimum to diphtheria, and refers to the statistics of von Villiers, who lost but 2 per cent. of the cases treated by the *cyanide of mercury*. The indications for the cyanide are: Diphtheria that is intense and threatening from the start, nares involved as well as the pharynx; putrescence, with foul-smelling breath; dirty gray exudate; rapid, feeble, small, intermittent pulse; extreme prostration; pallid and sodden countenance; moist skin; tongue coated brown or black. If diphtheria of this type may be treated with cyanide of mercury, and with results showing a mortality of only 2 per cent., it is certainly extraordinary. The *iodide of mercury* is especially adapted to strumous subjects, in whom the lymphatics are involved very early in the attack, and the other symptoms are mild. *Mercurius corrosivus* is indicated in the incipient stage, when prostration is not so great, exudate very slight, and other symptoms indicating a mild attack. *Mercurius protoiodide*, when there is swelling of the throat and membrane beginning on the right side, foetid breath, flabby tongue showing imprint of teeth, and especially if there is thick yellow coating at base of tongue. Among others, Dr. Kern mentions the following remedies, with their indications:

Kalibichromicum. Especially for laryngeal complications. Mucous membranes deeply affected and ulcerated; painful, difficult swallowing; stringy, tough mucus and hoarse, metallic cough; exudate firm, fibrous, yellow or yellowish-white, covering both tonsils, nares and larynx.

Lachesis. When the constitutional symptoms predominate over the local. The throat symptoms may be slight, but there is great prostration, slow, feeble pulse, cold, clammy sweat, and pain out of proportion to the local lesion. Left-sided exudation, livid, ulcerated mucous membrane, very painful deglutition. Dr. Carroll Dunham valued this remedy very highly in diphtheria.

Arsenicum Album. A remedy that is not used frequently enough in diphtheria. Throat much swollen, both internally and externally. Membrane of dark hue and very foetid. Thin, excoriating discharge from the nose. Patient restless. Urine scanty. Adynamic fever, and patient somnolent. The throat may be oedematous, as under apis.

Very extensive swelling of lymphatic and cellular tissues may direct attention towards *rhus tox.*

Crotalus horridus is the chief remedy when profuse epistaxis occurs, which marks many cases of the malignant type. This may show a decomposition of the blood.

Diphtheria antitoxin has been thoroughly proven, its champions are many and distinguished, its published statistics are overwhelming. We have used it, and have been disappointed in its effects. We shall continue to use it. "Auspicious Hope! a charm for every woe."

O. S. Haines, M.D.

CHATS WITH OUR FRIENDS.—Dr. Howard W. Long, of Philadelphia, and I were chatting recently about the treatment of coughs, especially the coughs of tuberculous patients. The doctor is a keen observer of people and things, hence we believe that his remarks upon the use of tuberculinum in phthisis and in the coughs of tubercular subjects should have a wider hearing. We shall give them as nearly verbatim as we are able. The doctor said: "It has now been about one year since my attention was first directed to the use of tuberculinum in the coughs of suspected tubercular origin, and during that time I have observed closely and carefully the effects of said remedy. The results of its administration have generally been satisfactory, and in a number of instances remarkable. It has ameliorated the distressing cough accompanying phthisis, and has undoubtedly benefited the condition itself. I admit that I was first led to use the remedy as an experiment in a case in which all the prescribed remedies had utterly failed to bring about an amelioration, but my results in this particular case exceeded my most sanguine hopes. After this experience I used it in other cases of like nature, so that at the present time, although the statement may lay me open to the charge of routinism, I must acknowledge that it has become invaluable to me in all cases of known or of suspected tuberculous origin. The symptoms indicating the remedy are somewhat varied, its beneficial effects apparently including both loose as well as dry coughs. I have thought that it is best indicated and most effective in the kind of cough for which we would think of Stannum. A loose, rattling cough, with profuse muco-purulent expectoration. I have seen cases in which the cough was violent enough to exhaust the patient, and in which the amount of expectoration was very profuse, yield nicely within a few days to Tuberculinum

30. So, also, in the dry, hacking, persistent cough which is such an important diagnostic feature of the earliest stage of tuberculosis, the remedy has been equally effective. My experience with the remedy has been confined to the effects of the 30th decimal potency, giving 5 drops in a third of a glass of water; teaspoonful every three or four hours. I cannot speak too highly of the therapeutic value of this remedy. It will not only alleviate the sufferings of those who have phthisis, but it will do more than this. I would like my colleagues to use the remedy in similar conditions." Dr. Long is very enthusiastic in his praise of the Tuberculinum. The literature of our school contains some equally favorable reports. For our own part, we have not seen as favorable results following its administration.

O. S. Haines, M.D.

SOME OBSERVATIONS UPON PHOSPHORUS IN SCURVY.—The leading article in the *Pacific Coast Journal of Homœopathy* for December, 1900, was a masterly paper upon the above topic, from the pen of F. F. Laird, of Los Angeles.

The writer says: "To the conscientious student of the homœopathic materia medica, no work is more fascinating, and at the same time more profitable, than opening the chestnut burr of symptomatology and finding therein the kernel that gives it value." Dr. Laird in his paper has certainly proven the specific (*i.e.*, homœopathic) relationship of phosphorus to scurvy, and his observations upon this point are most valuable. For instance, in the report of a post-mortem made upon Case I—a typical instance of "scurvy-rickets"—we read: "Every organ in the body, even the smaller vessels and capillaries, showed fatty degeneration so marked as to strongly resemble phosphorus poisoning." The following summary of the author's conclusions is interesting.

For a drug to be homœopathic to a given disease, both must induce their symptoms in a similar manner as to pathological changes and the time required to produce them.

Phosphorus and scurvy both induce fatty degeneration of all tissues, with consequent multiple hæmorrhages; and in both the process is essentially chronic. Hence, Phosphorus is the true homœopathic similitum to scurvy.

Phosphorus bears the same relation to scorbutic conditions as quinine to malaria and iron to anæmia—*i.e.*, the pivotal remedy.

Arsenic, mercury and sulphuric acid are, in the order named, the nearest analogues of phosphorus.

Rachitis and infantile scurvy have a common origin, and hence should find a common remedy.

In chronic poisoning, the hyperplasia of connective tissue (*i.e.*, cirrhosis, hepatic and gastric) is as truly an effect of phosphorus as is fatty degeneration.

Scorbutis, as a rule, is perfectly amenable to dietetic treatment, but in childhood frequently and urgently demands a curative drug.

O. S. Haines, M.D.

THERAPEUTICS OF CATARRHAL AND NEUROTIC GASTRIC AND INTESTINAL DISEASES.—C. Wesselhoeft, M.D., of Boston, in the January number of the *New England Medical Gazette*, has something to say about some remedies not usually selected for gastric diseases, because it is "not the fashion"—as if there was such a thing as "fashion" in homœopathic therapeutics. Ah! but the doctor is right, and there's the rub. He calls attention to the *Rhus tox.*

3x or 5x for the acute forms of gastritis, catarrhal, phlegmonous, and the catarrhal symptoms induced by ulceration and cancer.

In "Hughes' Cyclopædia" we may find the following gastric symptoms caused by *Rhus*: "Soreness of throat, with intense burning, extending to the stomach. Irritation extends to mucous membranes, redness and swelling of throat. Great thirst. Nausea and vomiting. Colicky pains throughout abdomen, especially during night, aggravated by eating or drinking. Diarrhœa frequent, with tenesmus, and the stools are bloody." It is very evident from these corroborated observations, as also from the very violent form of inflammation which *Rhus* excites on the skin, that it ought to promise relief if applied according to the homœopathic maxim in various forms of inflammation of the stomach. Wesselhoeft has used the remedy frequently in the acute gastritis of children, as well as of adults, where arsenic is usually given without result. *Rhus* is better than arsenic for these cases when there is loss of appetite, bitter taste, gradually increasing to nausea; vomiting; pressure in the stomach; nocturnal colic and diarrhœa.

It is, however, in those rarer forms of phlegmonous gastritis, and in cases of ulcer and cancer, that the writer would suggest the careful consideration of the *Rhus tox.* (Snader, of Philadelphia, has suggested it in membranous forms of enteritis.)

Another remedy, which fashion has very much overlooked in the treatment of acute gastritis is *Cantharis*, given in the 3x, or better, perhaps, higher than this.

Among the effects of *Cantharis* there appear cutting pains in stomach, umbilical region and epigastrium; burning pains in throat and stomach, nausea, vertigo, violent retching and vomiting, ardent thirst. Dr. Wesselhoeft thinks the remedy most useful in violent attacks of acute gastritis, and regrets that so useful a remedy should be thought to act only upon the bladder and kidneys.

In this paper the writer refers incidentally to the fashion of giving *Baptisia* in typhoid fever, because it is supposed to be a good remedy for the disease. He makes the startling assertion that neither its pathogeny nor provings indicate any activity of that drug, and claims that its symptoms bearing on typhoid are the results of the alcohol of the tincture. We cannot subscribe to this opinion, for certainly, when given upon the symptoms supposed to indicate it, *Baptisia* has done splendidly for us in typhoid. Its therapeutic effects are surely not the effects one obtains from alcohol in this disease.

The writer's remarks upon neurotic dyspepsias are very interesting. He says there are three species of neurosis which are very often associated with what the patient calls dyspepsia. These forms are hypochondria, hysteria and neurasthenia, and moreover these forms are often associated with each other. In the treatment of such cases, the remedy should be directed mostly toward the symptoms presented by the nervous system, of which the semblance of dyspepsia is only a part.

At the head of the list stand *Nux vomica* and *Ignatia*. The former should be prescribed for the following symptoms: "Great worry about patient's condition, he is anxious and wants to know the cause of this or of that sensation. Ascribes it all to his stomach, which feels to him as if 'bloated with gas.' Thinks he cannot digest food because this gas in his stomach causes so much

pressure. He eats little, and has irregular stools. There is nausea, headache in the morning and coated tongue."

Then there is the *Conium Maculatum*. This remedy is strongly suggested by the symptom of gas in the stomach, when there is no gas. Loud and long eructations often cultivated by habit, and the mental conjecture that he must get rid of the imaginary gas. Constipation associated with hypochondriacal introspection, or hysterical loss of self-control and nervous palpitation. (How common are such symptoms and how seldom do we think of the Conium.) *Helleborus* comes very near to it, where the patient suffers from melancholic depression, dulness of the senses and great pressure upon the vertex. Vertigo, flickering qualmsiness, nausea, empty eructations, burning in stomach and prostration complete the picture. If such symptoms are the result of actual cerebral irritation, *Helleborus* is undoubtedly indicated, and likewise, when they arise from a general neurotic condition, simulating acute disease.

Hydrastis Canadensis: Scattered throughout its provings are many neurotic symptoms, which should point to that remedy in cases of neurotic dyspepsia associated with catarrh of the fauces, larynx and bronchia.

Cimicifuga Racemosa: This remedy is much more far reaching than *Hydrastis*. The neurotic element largely prevails, together with digestive disturbances. Dull pain upon the vertex, faintness in epigastrium, nervous uneasiness, abdominal fullness, excruciating pain in bowels, much rumbling of wind. Thin, dark, offensive stools. With these go mental depression, and even suicidal tendencies; internal tremors in stomach; cannot fix attention; patient fears she will go crazy. This is the nervous condition, combined with digestive disturbances, that calls for the *Actea*.

O. S. Haines, M.D.

CEANOTHUS VIRGINIANA.—Dr. A. L. Blackwood reports the case of Mr. V., aged 31, who was suffering from a greatly enlarged spleen, very tender to pressure, accompanied by jaundice, emaciation and exhaustion, the whole being the result, presumably, of chronic malarial infection. After the chills had been controlled by quinine, there had been continual pain in the side and back, constipation, cough which aggravated the pain in left side. There was marked aggravation of pain and general symptoms during wet, cold weather. *Ceanothus tincture*, three drops every three hours, in one week produced an amelioration, and in three weeks' time there was no tenderness, the enlargement of the spleen had diminished, and the patient claimed that he was cured.—*The Clinique*.

O. S. Haines, M.D.

SILICA IN OCCIPITAL NEURALGIA.—Mr. L., aged 45 years, for the past ten years had been suffering from a constant pain extending from the nape of the neck up behind the right ear. It was throbbing in character, relieved by pressure and wrapping the head up warmly, but returned at once if the wraps were removed. One dose of *silica* 200 each night for three nights was the prescription. In two weeks the patient reported himself free from pain for the first time in ten years.—*Dr. A. L. Blackwood*. (Silica is a dependable remedy for chronic headaches, when the pain extends from neck to vertex, relieved by wrapping the head up warmly. It is the warmth rather than the pressure that relieves. The patients are over-sensitive, imperfectly nourished, and suffer from nervous prostration.)

O. S. Haines, M.D.

THE HAHNEMANNIAN MONTHLY.

APRIL, 1901.

THE URIC ACID STATES.

BY F. PARK LEWIS, M.D., BUFFALO, N. Y.

FROM the simplest living protoplasmic mass to the highest and most complex of animals the essential functions are the same—to come into existence, to pass through a more or less extended period of development, to produce others of like kind, then to pass through a series of retrograde changes, and finally to cease to exist as discrete and tangible entities, the elements entering into their composition passing back again into the world of matter from which they came. Whence came the quickening force which gave to inanimate matter the power of performing the independent functional actions which we call “life,” and whether it departed when its specific work was done, we have not to consider in this connection. Suffice it now for us to recognize this fact—that the amœba, a bunch of undifferentiated cells, is the prototype of the man, a multitude of groups of cells differentiated to perform an exact and definite work in a complicated economy. Inherent in each cell of this simple organism, floating in the sea and absorbing its nutriment by enfolding itself about the morsel and then throwing out the unused detritus, lies the potentiality of individual aspiration.

Conditions change, environments differ, and the need of the organism of a different mechanism to meet the slowly altering surroundings is responded to by something within the cell,

which is, again, the whole being in miniature; the internal structure of some of the cells undergoes modifications, a new form is given to them. They begin to gather in the lime which had been held in solution by the sea, and after arranging its molecules with a beauty and a perfectness beyond human knowledge and experience, the delicate bit of protoplasm becomes covered with a shell, and we have a diatome—one of the wonders of nature's workshop. A larger life is demanded; the pseudopodia no longer suffice, so the cells arrange themselves in concentric rings, and a worm is the product. 'Tis but the first step that counts. The upward progress having begun, it shall know no limit. The primordial cell contracts under stimulus; in it lies the promise of a finer mechanism to more accurately convey the sense of heat, and cold, and light, and pain, and that wonderful cell again responds, and nerves are developed, and muscles grow, and an eye is made. Now the progress is more rapid; special organs appear, that the more complicated mechanism may serve for the new needs, and the lamprey, with its gills, is followed by the air-breathing animal with lungs. Digestion has become a serious business, and the tube that sufficed for the worm has now its diverticulæ, which increase in complexity as the functions multiply. It broadens into a stomach, it extends into a long and tortuous intestine, into which special organs pour fluid designed to still further fit the nutriment for absorption. The being has grown great, and the nourishing fluid is carried in a net-work of tubes to the remotest part of the organism, and, having done its work, back again, to be freshly charged. Millions of cells having a specific function to perform are differentiated for that work and form organs, and from the one-celled being, with a vague, undefined instinct of aspiration responding from within to the demand from without, we have the mass of highly differentiated cells constituting the brain of man and capable of consciousness of divinity.

This, in a word, is the theory of evolution accepted by the most profound students and philosophers of to-day as an adequate expression of the teleological processes of existence, and must be borne in mind, if the normal and abnormal cellular activities, the physiology and pathology of man, are in any measure to be comprehended.

The essential thing is the same. From one single cell has grown man, and in that single cell lie potentialities which are to be reproduced in generations yet unborn. The features, the voice, the mannerism, the tendency to disease, the qualities that blossom forth in genius which a man possesses in common with his grandfather or his great-grand-aunt, were all present in a nucleated bit of protoplasm enveloped by a limiting wall, and the whole so tiny that it requires the highest skill of the mechanician to make a lens of sufficient amplifying power to make it visible. In the essential activities of that cell and those that come from it, and the countless multitudes that come from each of these, each giving its distinctive quality to the next of its progeny, lie the life possibilities of the creature that is to be the ultimate product of their united forces. If the ultimate determination of the activities of that cell are to produce a gnat, the development is rapid, the period of maturity short, the retrograde changes speedy, and the life-history of the insect is measured by days; but if it be the ovum of an elephant or a crow, its years may exceed the limits of a century. There are long-lived families and short-lived families. There are those in whom defects in hearing are produced generation after generation, and others in whom gout and rheumatism are their unfortunate inheritance, and in the unicellular organism in which the life of the creature began were the potentialities which were ultimately to direct the vital activities, in all of their complicated changes, through years which were yet to come. It were idle to speculate how this mysterious property is evolved, but it would seem that, as each cell arises from its immediate progenitor, it carries with it the qualities which its ancestor possessed; and as all the differentiated and grouped cellular structures were derived from the simple original cell, so the properties of each, fitting it for its special work, can, under altered conditions, be assumed by others, and the structure designed through centuries of adaptation for the performance of a special work may, when necessity impels, take on itself the work and functions of widely different structures, and it may vicariously perform a work for which it was not specially developed. In the unicellular organism all of the functions of nutrition, reproduction and ultimate degeneration are profounded by the simple cell; in the multicellular organ-

ism, where complicated processes are necessary, the failure on the part of one group of cells to fully perform its allotted work makes supplemental work requisite on the part of another group, originally designed for quite other, and perhaps wholly different, functions. This must be borne in mind if we would understand the essential nature of either physiological or pathological activities. The skin and mucous membrane have been known as media through which the menstrual molimen may find expression; and in cancer the cells of one tissue may be found in structures remote and wholly different in form and function from those in which they originated.*

This is especially noticeable in aberrations from normal metabolism. In the life-history of an organism during the period of growth an excess must be retained in its structures of the total increment over the total excrement. During the period of adolescence, that which is taken in the system must exactly balance that which is thrown off.

While, during the period of adolescence, there may be an excess, or there may be a deficiency, or there may be a perfect balance in what is taken in and what is carried away, yet in the complicated chemical processes which take place the rearrangement of the end-products is such that in the development of energy there is an incomplete transference of the substance employed into the special form of energy which it is designed to create, so that, instead of innocuous products being formed which are easily disposed of, combinations are retained which are irritants to the normal cell, and we have the phenomenon of toxæmia in one of its phases. In this connection let me refer to the classical description by Gowers† of "Acute Ascending Myelitis," in which he discusses in detail the manner in which an organic or chemical toxin, acting as a ferment, so modifies the albuminoses in the body that a harmless substance is transformed into one highly poisonous, and having a specific action on nerve structures. The manner in which this occurs suggests the probable action which takes place under certain conditions producing blood-states actively irritant to special tissues. This is admirably illustrated in the convulsions of infants produced by overfeeding, and in puerperal eclampsia.

* "Cancer and its Complications," Jennings; Jonathan Hutchinson; Wood's Medical and Surgical Monographs, p. 591.

† Clinical Lectures, p. 119.

Now, in the protean forms of disease which are broadly grouped under the general designation of the "Uric Acid States" we have, somewhere in the complicated and elaborate metabolism which takes place between the ingestion of the food-stuff and the elimination of its detritus, an imperfect transference of one form of matter into another, energy resulting, with by-products, at least five of which have been isolated, which are in varying degrees toxic.

Croftan,* in an admirable review of the most modern uric acid theories, shows that uric acid is itself innocuous; that its deposit in the tissues follows an irritation produced by some one or more of what are termed the aloxuric bases, and that these, in turn, are derived from nuclein, which comes from the nuclei of the leucocytes of the blood.

Leucocytosis is due either to an excessive ingestion of proteids or a failure to use the white corpuscles in the organic functions for which they are designed.

Now, the amount of material which is employed in producing a physiological result is dependent upon two factors: first, the amount of energy into which it is to be converted; and, second, the functional activity of the cell by which this change is to be effected.

It will be evident, therefore, that in the study of a metabolism resulting in toxic by-products, both of these factors must be considered.

The amount of the fuel which an engine requires must be gaged by the work which it is to do, and if the fuel be in excess, combustion must be imperfect, and the flues will become occluded.

So, in the human economy, as the end to be attained is the complete transference of the food-stuff into energy, the amount and character of the pabulum must be measured by the activities to be produced. The whole problem, then, is the change of matter into other matter—releasing energy. In our highly evolved civilization, the amount of muscular effort employed by the average individual is small. We are a nervous people, mentally active; but in a large number of the cases in which the aloxuric poisons are developed physically inactive,

* *Journal of the American Medical Association.*

proteids are taken in excess, and physiological methods of eliminating them are neglected. A violation of physiological laws—sedentary living—prevents full muscular development of the abdominal walls, the vermicular motion of the intestines is lessened, the circulation in the liver grows sluggish, constipation results, and the most important of the channels of elimination is defective.

But it must not be forgotten that the intestinal tract, important as it is, is but one of the passages through which the detritus is carried away. The blood, loaded with detritus, throws added work on the strainers, and we find indican and other evidences of imperfect digestion in the urine; but the skin and lungs are equally important. The root of the trouble, then, is deficient oxidation—combustion is imperfect.

If we will reach these serious conditions, then,—which mean growing old rapidly or slowly, increased inability of the cell structures to respond to stimuli,—we must consider, first, proper alimentation, limiting the ingestion of proteids; second, suitable exercises, promoting functional activity; third, maintaining a regularity of the bowels through suitable physiological measures; fourth, aiding the kidneys by diluting the filtrate; in other words, flooding the sewers by giving large quantities of pure water free from lime salts; fifth, maintaining an activity of the skin, preferably by hot-air baths; sixth, by hastening oxygenation by an abundance of pure fresh air.

These are the physiological measures. It does not seem conceivable that permanent results can be obtained by the means of simple solvents, such as sodium salicylate, etc., unless these means are also employed.

We are forced back, then, to a recognition of the fact that all the essential cellular activities are molecular, and it is by the ability of the cell to do its work normally and completely that that perfect equipoise which we term health is maintained. The pabulum may exactly balance the amount of energy produced, and still the metabolism is imperfect; waste and repair are not equal, and toxic detritus remains.

“Taking into consideration all the fine touches which make up the characters of an individual organism,” says Foster,* “and remembering that these are the outcome of the different

* *Vide* Art. “Physiology,” *Encyclopædia Britannica*, Michael Foster.

properties or activities of the several constituent tissues of the body working through a delicately balanced, complicated machinery, bearing in mind the far-reaching phenomena of heredity by which the gross traits and often the minute tricks of the parents' body are reproduced in the offspring, if there be any truth at all in the views which we have urged, tracing the activities of the organism to the constitution of its protoplasm, this must be manifold indeed. The problems of physiology in the future are largely concerned in arriving, by experiment and inference,—by the mind's eye, and not by the body's eye alone, assisted, as that may be, by lenses yet to be introduced,—at a knowledge of the molecular construction of this protean protoplasm, of the laws according to which it is built up and the laws according to which it breaks down; for these laws, when ascertained, will clear up the mysteries of the protean work which the protoplasm does."

"We have, in speaking of protoplasm," he continues, "'construction,' 'composition,' 'decomposition,' and the like, as if protoplasm were a chemical substance. And it is a chemical substance in the sense that it arises out of the union of coincidence of certain factors, which can be resolved into what the chemists call 'elements,' and can be at any time, by appropriate means, broken up into the same factors, and, indeed, into chemical elements. This is not the place to enter into a discussion upon the nature of so-called chemical substances, or, what is the same thing, a discussion concerning the nature of matter; but we may venture to assert that the more these molecular problems of physiology, with which we are now dealing, are studied, the stronger becomes the conviction that the consideration of what we call 'structure' and 'composition' must, in harmony with the modern teachings of physics, be approached under the dominant conception of modes of motion. The physicists have been led to consider the qualities of things as expressions of internal movements; even more imperative does it seem to us that the biologist should regard the qualities (including structure and composition) of protoplasm as in like manner the expression of internal movements."

Elsewhere in this valuable summary of modern physiological experiment and reasoning Foster says: "It is obvious that almost every physiological inquiry of any large scope is, or

sooner or later becomes, of a mixed nature. On the one hand, investigation has to be directed to the processes taking place in the actual tissue-elements, in the protoplasmic cells and modifications of cells. These are essentially of a molecular, often of a chemical or chemico-physical, nature. In the problems thus raised, matters of form and structure other than those of molecular structure, which no microscope can ever reveal, are of secondary moment only, or have no concern in the matter at all. These may be spoken of as the purely physiological or as the molecular problems. On the other hand, the natural results of these tissue-activities are continually being modified by circumstances whose effect can be traced to the mechanical arrangements under which the tissue in question is acting, whence arise problems which have to be settled on simple mechanical principles."

Creighton,* after considering the gout due to excess, that of workers in lead, in porter drinkers, and of heredity, concludes that there are still other cases which justify the somewhat wide definition of gout as a form of dyspepsia.

Now, if these disturbances are due to derangements in the cellular molecular activities, we may assume that any change for the better that is other than transitory, any modification that can result in a cure after the metabolism has been modified by diet and habit, must arise from alteration of these molecular movements from discords to harmonies. The analogy of the laws of physics is at least supposable, and possible modifications by the establishment of molecular interference-waves is worthy of consideration, and has been suggested by so great a physiological reasoner as Hering.

Now, it is a mathematical law that things that are equal to the same thing are equal to each other. It is quite fair to assume, therefore, that if we can produce by artificial means a condition similar to that which arises in any of the uric acid states, whether it is due to the toxæmia of one of the xanthin bodies or not, that the molecular activities are the same in this condition, and to that phase of disease to which it corresponds.

This must be the explanation of the restoration of normal function in serum therapy. The closer also, then, the approxi-

* *Vide* Art. "Pathology," *Encyclopædia Britannica*.

mation of the artificial to the disease condition, the more rapid and the more simple the substitution of the normal harmonious activities for the dissonant and disturbing ones. It has been found that when a substance normally inert, as the pollen of lycopodium, has been reduced by trituration with some hard substance like the crystals of milk-sugar, molecular activities of a specific character are developed.

When this substance so reduced, or perhaps we should say excited, is given by ingestion to one in normal physical condition, it so disturbs the normal functional activities that the secondary digestion is inefficiently performed. It is found that starches are imperfectly acted upon in the small intestine, the food-products ferment, the abdomen becomes distended. This occurs several hours after eating, and is followed by a deposit of urates in the urine, and a number of other symptoms which might be given in more exact detail.

Now, it is a most important therapeutic fact that when the condition produced by the drug can be made to correspond with that which has arisen as a manifestation of disease, the molecular movements become harmonious, and the evidences of disease quickly, simply, and easily disappear.

Now, the writer has found that beginning cataract is not infrequently associated with these evidences of disturbed metabolism, and that the relief of the digestive difficulty is often followed by better nutrition of the lens, and a cessation of the atrophic degeneracy and improvement in vision. Cases might be cited in illustration of this proposition, but they are reserved for a special paper on this subject.

Of course the drug and the condition cited are but one instance from a large number in which the pathogenetic power of substances of molecular fineness has been carefully studied, and this power to dissipate allied disease conditions has been so frequently demonstrated that it is recognized by thousands of trained and acutely observant minds. It is not necessary to enlarge upon it now. We would seem to possess here, however, an explanation of many otherwise obscure facts, and it would give warrant to the belief that when we have accurately harmonized the drug and the disease, rendered it molecularly active to a degree corresponding with that normally existing in the cell, we shall have developed a system of therapeutics which shall be scientific, and therefore efficient.

SURGICAL RESOURCES IN INTESTINAL OBSTRUCTION.

BY CHARLES LESLIE RUMSEY, A.M., M.D., BALTIMORE, MD.

THERE are several different plans upon which a classification of the various forms of intestinal obstruction may be based. I present the usual one, founded upon pathological anatomy.

1. Strangulation of the gut by bands, extensive adhesions or apertures.
2. Volvulus.
3. Intussusception.
4. Obstruction due to neoplasms.
5. Compression by tumors external to the gut.
6. Obstruction from foreign bodies, such as gallstones and enteroliths.
7. Obstruction caused by fecal masses.

There is no definite topography of the small intestines except at their extremities. The topography of the large bowel is more definite. As bearing upon all operations on the intestines, especially on resection and suture, the anatomical structure of the intestinal coats and the mode of attachment of the tube to the mesentery are of supreme importance.

The mucous membrane is fully two-thirds of the thickness of the walls of the intestines. It is not difficult to pick up at each stitch a thread-like piece of submucosa without incurring the danger of passing into the lumen of the gut. The resistance offered by the submucosa is readily appreciated.

Again, the divergence of the layers of the mesentery begins at a distance varying from two-thirds to three-fourths of an inch from the wall of the gut, and we thus get a triangular space filled with fat, intestinal vessels and lymphatics, bound by the mesentery on two sides and bowel on the third. The arterial loops, to supply the intestines lying in this space, come to within a third of an inch of the gut. The straight vessels, which pass directly on each side of the interspace to supply the bowel, are given off from these arterial loops. These statements are made that it might be more forcibly expressed, if the

vitality of the bowel is to be assured, the anastomosing loops should be injured as little as possible. Triangular resection of the mesentery should, therefore, be avoided as far as possible. The layers of the mesentery at their attachment to the bowel are very lax and easily drawn together by purse-string sutures, so that they need not be in the way even if they are left behind.

Surgical resources in the treatment of "Intestinal Obstruction" should be prompt. While chronic obstruction is more frequently met with in persons advanced in years, and this character of obstruction is usually met with in large intestines, it suddenly emerges into the acute form, which is always imminent to life.

In these days of modern surgery, taxis and massage, scientifically practiced, have a very limited range of application in the treatment of "Intestinal Obstruction." Its utility serves in that class caused by a foreign body, fecal accumulation, or an enterolith. I advise as valuable adjuvants the evacuation and irrigation or lavage of the stomach, and evacuation of the colon by copious rectal injections. In the administration of a large enema to wash out the colon the long rectal tube is superfluous, unless it be to evacuate the gaseous distention of the colon, or to detect and locate an obstruction below the sigmoid flexure. In Hegar's knee-chest position the fluid from an ordinary fountain syringe and short nozzle will follow the course of the colon and advance as far as the cæcum.

I am impressed that abdominal distention, excepting when it is in volvulus, is not such a prominent symptom as one infers from the text-books and his early teachers. Peritonitis is singularly constant in volvulus. It develops early, and may account for the abdominal distention. The other symptoms are too well known for me to discuss here, except to state I am particular to elicit any history of previous attacks of abdominal disturbance. Though most surgeons justly contend that refinements in diagnosis are unnecessary when acute abdominal symptoms exist which demand immediate interference, yet it is obviously desirable before operation to ascertain as exactly as possible the seat and nature of the lesion present. This, however, must not be done at the expense of valuable time. If the lesion present can be diagnosed, a necessary operation will be hastened, and an unnecessary and harmful one avoided.

I should not advise against an exploratory operation if the lesion is not clear to me. I find diagnosis of these abdominal lesions most difficult at the time a surgeon is often called in consultation.

There is not the least reason for supposing that the bowel, when it has been strangulated for a certain length of time, has the least power of removing itself from the constricting agent. What we know of strangulated hernia would support this impression. A piece of bowel that has been strangulated in an external hernia and has then been reduced into the abdomen may be the cause of one of many different forms of intestinal obstruction. I do not allude to results immediately following the reduction of hernia, but to results that are comparatively remote. The reduced loop may adhere to the abdominal parietes, and become obstructed by bending and by the change known as "traction effects."

In reference to volvulus, I have had no surgical experience. I saw one case in the London Hospital which was rapidly fatal, and believe from my study of the record of cases it has the most unfavorable prognosis of all forms of intestinal obstruction.

The subject may be most conveniently studied under the following heads:

1. Volvulus of the Sigmoid Flexure.
2. Volvulus of the Ascending Colon and Cæcum.
3. Volvulus of the Small Intestines.

Intussusception is probably the most common variety of obstruction. It depends upon irregular action in the muscular walls of the intestines. The precise nature of that irregularity may be open to question. My clinical experiences support the association of intussusception with disordered intestinal movements. The attacks of colic are conspicuous which are early and marked. In examining the records of patients who have been the subject of elimination of the bowel, at least 50 per cent. of the patients die from effects directly connected with the intestinal lesion, or with the eliminating process itself. The mortality is conspicuously affected by the age of the patient, as 50 per cent. of these cases are between 50 and 60 years of age. The use of water- and air-pressure is justifiable in all cases of less than twenty-four hours' duration. I suggest a few whiffs of chloroform be given to children, which aid very

much in restraining the efforts at expulsion on the part of the child, thereby allowing a great amount of water to enter the bowel. It is my experience that children bear abdominal section very well. I am quite satisfied that recovery will almost invariably follow in all cases in which the operation is performed within the first twenty-four hours. The relationship of recoveries from strangulated hernia and intussusception with regard to previous duration is very similar. The longer the duration the greater the mortality, due to the same cause or causes in each disease—shock, exhaustion, gangrene and sepsis. On the other hand, the main factors of expected success in relieving intussusception depend upon the reducible condition and freedom from septic changes. In reducing the gut, it must not be done by traction, but by the means of gentle pressure exerted through the intussusciens upon the apex of the intussusceptum. This will drive the intussusceptum from within the intussusciens. Pressure need never be so severe as to produce any injury to the integrity of the gut, as, in all cases in which there are neither gangrene nor adhesions, reduction is readily accomplished. Should the patient's condition demand haste, then and then only should an artificial anus be made, while in the case in which haste is not a factor, typical resection with end-to-end anastomosis is the operation to perform.

The obstruction due to neoplasms is dependent upon the variety of tumor. Of the benign variety, the adenomata and polypi are the most frequent, but of these causes of obstruction I have had no experience.

Cancer of the rectum can be recognized at an early stage, and the resection of the neoplasm is often accomplished with brilliant results. If the tumor is located farther up in the large bowel or the small intestines, the results of the operation are not so promising, for here the recognition of the growth is possible only at an advanced period, and by that time other adhesions with other organs and cancerous affections of the glands have already taken place. Excision of the tumor and resection of the intestine in the neighborhood of the neoplasm, with an end-to-end anastomosis, should be practiced whenever feasible. In case, however, total resection is impossible, an entero-entrostomy or an entero-colotomy, or, if the cancer is situated in the rectum, a colotomy will be a benefit. These

operations are palliative in nature and prolong life, at the same time making it more comfortable. They are intended to allay the symptoms of obstruction and to carry the faecal matter over a new route in passing through, and thus not irritating the cancerous area.

On October 19, 1899, I operated on a cancerous growth located in the upper part of the rectum. There was a decided ring causing chronic obstruction of the bowel. My effort was to perform a telescopic colo-rectostomy after the method of Kelly. I found this was infeasible, when I performed a Kraske operation with the sacrum taken off on a line beginning just below the level of the third sacral foramen. While my patient is still living, the end is not far off, and I believe it would have been better to have performed an inguinal colotomy. I have performed three Kraske operations, all of which were accompanied by fistulous tracts where the original rectum and anus were.

I should like to conclude this paper by a summary of the treatment of typhoid perforation of the bowels as laid down by Keen :

1. The surgeon should be called in consultation the moment that any abdominal symptoms indicative of possible perforation are observed.
2. If it is possible to determine the existence of the pre-perforative stage, exploratory operation should be done under cocaine anæsthesia before perforation, shock and sepsis have occurred.
3. After perforation has occurred, operation should be done at the earliest possible moment.
4. We wait till the primary shock, if any is present, has subsided.
5. The profession at large must be aroused to the possibility of a cure in nearly, if not quite, one-third of the cases of perforation, provided speedy surgical aid is invoked.

SOME POINTS ABOUT PERCUSSION OF THE CHEST.

BY EDWARD R. SNADER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Germantown.)

PERCUSSION of the chest is capable of furnishing information of the most conclusive and important nature. As percussion is ordinarily performed, however, much knowledge is missed by faulty technique. You have all seen men hammer away at the chest in a perfunctory sort of way, as if they were going through a prescribed method, yet without the slightest feeling that they were about to derive from the procedure any information of decided value. You have seen men pummel the thorax and elicit a great volume of sound, and have been perfectly conscious all the time the percussor was going through the manœuvres that he was not learning one iota of a big fund of information that was in the chest for the finding. Some men do not seem to apprehend what they are percussing for. In a vague sort of way they realize that it is the proper thing to do, but for the life of them they could not tell you what sort of information they expected to derive from the employment of this important method of physical exploration. Those who have this vague conception of the field of usefulness of percussion certainly miss one of the greatest possible helps in thoracic diagnosis. The interpretation of a group of signs may depend entirely upon the character of the percussion note found in connection with those signs.

Percussion looks to be one of the easiest of all the methods of physical exploration, and yet, practically, it is one of the most difficult of application and acquirement. You can be a splendid auscultator long before you can have even a mediocre skill in percussion. It is true that in auscultation you have an infinitely greater number of sounds and their variations to study, analyze and synthesize, if you please; but, no matter how numerous the sounds we hear, we have personally nothing to do with their mechanism or production. The patient's physical condition evolves these sounds. We can possibly alter their intensity, modify their pitch and enhance an existing

sound-quality by securing deeper respirations or by the use of the patient's voice; but it is beyond our power to seriously modify the signs found by auscultation. Hence, notwithstanding their practical infinity in variety, these sounds, and their myriad modifications, may be studied calmly and dispassionately. It is evident, too, that in percussion, instead of dealing with a multiplicity of acoustic phenomena, as in auscultation, we have practically to deal with but four sound-elements, namely, intensity, pitch, quality and duration; but percussion is made difficult because of the fact that all these sound-elements are seriously affected by our manner of eliciting them. In other words, we produce the sounds we study, while in the auscultatory phenomena, as a rule, the sounds to be studied are already within the thorax, ready-made, as it were, awaiting only our interpretation of their significance. In the production of the percussion sounds, therefore, our attention is divided between the technique necessary to bring out those sounds and an analysis of the sound-elements produced by the act of percussion. This is readily shown by the fact that we much more readily appreciate changes in sound when some one else is percussing than when we ourselves percuss. Differences in technique, then, have much to do with the facility with which information is derived from auscultation, compared with the information derived from percussion. Besides, masterly skill in percussion demands not only the good ear required in auscultation, but also an exquisite and almost unconsciously applied technique. In other words, you must percuss with perfect technique so frequently that the technique itself requires no thought for its carrying out, and your attention is left entirely free to be occupied by the sound-phenomena you elicit. Such a degree of perfection in technique requires a long time to acquire. Because the method of percussion is apparently so simple in its application, one can hardly realize that special skill is necessary in its performance. I may be pardoned, I trust, if I insist that not one percussor in one hundred can recall the text-book rules for the performance of percussion, and this would make no difference, practically, if the percussor had imbibed the principles of procedure to such an extent that the rules had become an unconscious part of his manner and method; but the vast majority of chest-pounders do not have

the slightest conception of the necessity for the most delicate technique, if I may so misuse the term, in order to become masters of the extremely valuable information to be obtained only by percussion.

A percussor must be in a mental attitude toward the examined subject that is twofold in character; he knows, or should know, beforehand that there will be certain phenomena of sound that he is sure to discover, and that there are certain other phenomena that it is possible to discover, and that await his intelligent elicitation. In any other frame of mind than this a chest percussor would be much like a man who pounds a box containing merchandise of an unknown kind and expects thereby to tell its contents.

A percussor of any powers of observation whatever soon learns that Bill Jones has a very different percussion note from that found in the broad bosom of George Washington Smith, all within natural limits. He knows that this fact gives a solar-plexus blow to an ideal percussion note; he knows that he may have all varieties of percussion notes within normal limits, and that a sound that would be pathological in one chest would in another be a representative of a perfectly healthy lung. He is not, then, in his search, trying to find a percussion sound like one he heard in another case, but is studying the chest before him without reference, ideal or otherwise, to any other. He soon learns, too, that there is a scarcely perceptible, but nevertheless definitely recognizable, shade of dullness at all parts of the right side of the chest, where underlying organs do not interfere with the transmission of sound or modify it, as compared with the left side, and a knowledge of this normal difference in the two sides of the chest prevents him from making the error of attributing the dullness at the right side of the chest to pathological conditions. He knows that the percussion note varies greatly in the left infra-mammary region, and before he declares that the dullness he finds there is due to a pulmonary consolidation he ascertains when the examined subject dined, and, if he elicits a tympanitic note in the same region, is likely to decide, other signs agreeing, that the man had better change his boarding-house and lunch off something beside the circum-ambient air.

The practical percussor does not expect to find that the per-

cussion note over the posterior portion of the chest will be as ringing and resonant as over the upper anterior portion of the chest, because he knows the thick muscles along the spinal column interfere with the transmission of the resonance from within, and that the scapulæ form a bony barrier for damming back the sounds from the lungs beneath. A percussor who goes about his work with an intelligent appreciation of what he is doing, does not expect to find the sounds elicited by his strokes upon the upper part of the chest to be of the same intensity and quality at the outer part near the shoulder as near the sternum, for he knows that there is a big air-containing tube just beneath the upper part of the sternum that makes the sounds he produces by percussion more resonant than those in any other part of the chest. In other words, if a man attempts intelligent percussion of the thorax, he must, in his mind's eye at least, see the structures he is about to strike upon. He must see within the bony cage, formed by the ribs and blanketed over by the muscles, to drown out the song of the birds of life within, the respiratory murmurs, the lungs *in situ*; apprehend that they are moving structures, see their lobes and fissures, view the pulsing heart and the great vessels departing from the vital pump, note the division of the bronchi into its large, small, smaller and very small tubes, and the myriads upon myriads of little lungs attached to those tiny tubes; must see that the diaphragm marking the ebb and flow of the air-stream that floats the ship of life, and apprehend, too, that the midriff is holding the liver in leash and preventing its too great encroachment on the thoracic space, lightly anchors the moving spleen, and just pushes off the upper border of the left kidney. The practical man sees all this in his mind's eye, and keenly senses that he is examining living structures, and is not pounding for form's sake, as over a wooden box. This mental position is but one side of the dual apprehension one should have when he percusses the chest. He also fully appreciates what he can discover. He knows the limits of the method of percussion. He realizes that the physical conditions he is likely to discover, nutshelled into practical shape, are but three, namely, excess of air in the air-cells, air in a cavity, and complete or moderate consolidation of the structures beneath the ribs. He may discover other subsidiary information by the method of percussion,

but he knows that one of these three physical conditions, or a condition of normality, is all that he may learn by percussion, so far as the lungs and pleura are concerned. Of course, too, he can outline the heart, its superficial and deep spaces, and tell whether the liver is pushing up too far, or whether the spleen exceeds its normal limits. You can realize the immense importance of the information to be obtained from the heart and other organs, but it takes some consideration to realize that volumes could be written under each one of the three heads, excess of air in the air-cells, air in cavities, and partial and complete consolidation. Think for a moment of the emphysemas, persistent and acquired, that would be revealed by the presence of the percussion sign indicating an excess of air in the air-cells. Think of the significance, diagnostically and prognostically, of the discovery of the sign indicating air in a cavity, either in the lung structures or in the pleural cavity. It is a condition that may be found in any disease capable of forming an excavation in the lungs, from phthisis pulmonalis and abscess to gangrene and a breaking-down neoplasm, and from pneumothorax, however produced, to an upward hernia through the diaphragm. Think of the numberless diseases and conditions, of the most diverse pathology, that are suggested by the presence of the signs indicating slight or considerable consolidation. At one time or another nearly all pulmonary diseases and pleural maladies, no matter how diverse their symptomatic phenomena and pathology, beginnings or onward progress, have partial or complete consolidation as part of their recognizable physical signs. There is a range from simple catarrhal pneumonia to tumor, from simple pleural effusion to empyema. One should, then, approach a chest for the purpose of percussing with a just conception of what he will find if the thoracic tissues are normal, and what he can find if the chest is not normal. This mental attitude is imperative. Without such an attitude of the brain toward the subject of investigation, one might as well expect to note the revelations of the microscope without eyes. The knowledge of what he expects to find, that is, of the disparities in the percussion notes in the various thoracic regions, at once gives him something that anchors him to a basis of comparison, and dissipates any ideal conception of what he should find. He ascertains certain

phenomena, and it is by comparison with these discoveries and readily-appreciated signs that he is enabled to say at once that an abnormal percussion note is or is not present, and, if present, he immediately recalls to mind the disease of which this sign is characteristic, and by combining it with signs discovered by the other methods of physical exploration, and his knowledge of the symptoms and pathological laws of disease, is enabled to determine that the percussion note he has elicited is indicative of a specific physical condition, which specific physical condition is associated with a disease which he is now ready to name. By the discovery of any one of the three particular physical conditions ascertainable by means of percussion he is immediately led along a special line of inquiry. Without a just appreciation of the normal chest and its disparities, and a conception of the possibilities of percussion in the way of the limits of its capabilities to furnish diagnostic data, one examining the chest has no more right to think he will obtain definite results than he would be justified in believing that he could, by pounding on a wash-board, anticipate hearing a sonata from Chopin.

The more important rules for the performance of percussion, upon which special stress is made by text-books and teachers, are that the chest should, first of all, be inspected, in order to determine the presence of a deformity in chest formation; for if a deformity be discovered it will affect both normal and abnormal notes, and must be allowed for in any attempted comparison of the several chest regions, else error will be sure to result. In nine out of ten cases the chest should be practically bare, or at least the clothes so arranged that easy access can be had to all parts. The percussor should place himself in such a position to the subject to be examined as to hear the sounds he elicits by percussion as nearly as possible at the same distance from their point of production. It is only too obvious that this rule is frequently violated, and an examiner receives his sounds derived from his strokes at varying distances, and consequently frequently draws improper conclusions. A rule of importance in regard to the patient is that the shoulders, the arms, either sitting or lying, and the body generally, must not be awry. The patient's two sides of the chest must be as nearly symmetrically disposed as possible, and, if for any reason

this is not practicable, due allowance must be made in the comparison of the two sides. A faulty position alters muscle tension in the external chest-walls, and will give you variations in intensity, pitch and quality that may lead to error. We are told, too, to strike with exactly the same force of blow in corresponding regions, preserving at the same time the same degree of condensing pressure with the finger used as a pleximeter. It is perfectly obvious that unequal blows will be sure to produce notable differences in resonance, and be sure to interfere with the drawing of a correct inference as to the presence or absence of certain sound-elements. Failure to appreciate the value of this equal pressure and equal force in the successive blows struck while percussing is responsible for a great many failures to derive from the method of percussion information that is reliable. It is somewhat difficult to measure the exact amount of condensing pressure you are using on one side of the chest, and exert exactly the same amount when you compare the percussion note you have elicited with one in a corresponding region on the opposite side of the chest or in a region used for purposes of comparison on the same side. Yet this must be done, if real success is to be secured. If the sustaining of equal pressure is difficult, the delivery of successive blows with equal force is still more so, for the temptation to pound harder when you come across an area that you suspect to be abnormal is almost irresistible, and it takes some time to conquer this natural tendency. If you cannot avoid this temptation to deliver more forcible blows, you are sure to produce almost any kind of a percussion note you want, except absolute flatness, either in the area you first suspected to be diseased or in the area you use for comparison. It is only too obvious that differences in the force of the percussion blow will produce equally striking changes in the intensity, pitch and quality of the sounds elicited. The type of perfect percussion is the monotonous ticking of the clock, greatly exaggerated. A very common fault is to deliver the last blow of a series a little more forcibly than the preceding ones, very much after the fashion of a carpenter driving a nail, when he gives the final settling blow. This period blow, if I may so call it, seriously interferes with the proper transmission of the sound-waves derived from the previous blows, and is not a proper means of carrying

out percussion. It is a fallacy to suppose that it is necessary to make the percussion-blow forcible enough to bring out a great volume of sound. Indeed, a great amount of resonance often defeats the very object of percussion, namely, the investigation of small areas; for of necessity a forcible blow must bring the sound from a much greater surface than one of moderate intensity, and the volume of sound drowns out the sound-characters derived from the resonance of small areas. It must be remembered that the primary object of percussion is not to produce a big volume of sound, but rather to elicit a note of sufficient loudness to permit the resonance to be studied according to elements derived from intensity, pitch, quality and duration, although elements ascertainable from the duration of sounds may practically be ignored, for the sound-characters furnished by alterations in the intensity, pitch and quality of sounds are always amply sufficient to differentiate normal from pathological notes and separate the pathological notes from each other. The only note not recognized by changes in intensity, pitch and quality, if I make the bull, is a percussion sign that is the most easily discovered of all the morbid percussion signs—namely, flatness, which is a complete negation of intensity, pitch and quality, for it has neither. It is practically the absence of all sound, save that made by your percussing fingers.

With a perfect technique, the very essence of skill in percussion is the ability to appreciate and give due weight to the sound-elements of intensity, pitch and quality. Changes in intensity are the most readily recognized, but are not so important as pitch, for heightened pitch of sound enters into the recognition of all the morbid percussion signs that have any pitch. Changes in the quality of sounds are appreciated with tolerable ease, but the three elements must always be taken into consideration before coming to a positive conclusion. Whenever a percussion note is higher pitched than normal, taking into consideration, of course, the normal differences of pitch in the several regions, you may be sure that there is present an abnormal percussion note, and the particular one is discovered by further interrogating the quality and intensity of the sound.

My remarks have been confined almost exclusively to per-

cussion as performed by nature's instruments, the hands, because they are the best, and, further, because he can have no true skill, nor true technique, who is not absolutely familiar with hand percussion. Personally, I have occasionally found the stroking percussion with the phonendoscope of some value, but of nothing like the advertised utility. A much better way of appreciating changes in pitch and quality, when the chest resonance is unusually dead, is to auscultate at the same time that you percuss; that is, with a binaural stethoscope, its bell not pressed against the chest, as in ordinary auscultation, but hanging carelessly against the chest-walls, its open mouth ready to receive the sound-waves as you produce them by your percussing stroke. Differences in pitch are by this procedure rendered startlingly distinct. It is seldom necessary, however, to reinforce ordinary percussion by thus combining auscultation therewith.

Percussion in very thick chests and over large mammary glands is thought by some to be impossible; but skillful pressure and condensation of the tissues will secure sufficient resonance to render investigation by percussion conclusive. The same is true of the scapular regions, which some observers regard as inappropriate for exploration by percussion. I have by no means exhausted the subject of the importance or of the technique of percussion. If I have but renewed the interest in this method of investigating thoracic and cardiac maladies, I shall have served the real intent of this paper.

In conclusion, let me say that a full appreciation of the disparities in the normal chest, a knowledge of and practical skill in the technique of percussion, and an exact appreciation of the kind of information discoverable by the method, is the basis of success in percussion, and that no man in the practice of medicine can afford to be without the knowledge obtainable from this source.

INCREASE IN WEIGHT OF INFANTS FROM BIRTH.*

BY WALTER SANDS MILLS, M.D.

Physician to the Metropolitan Hospital, Department of Public Charities, New York City.

THE subject that I am going to bring before you to-day is one of great importance, and one that, to me, is of fascinating interest. I propose giving you the results of a series of investigations made in the weighing of infants during my service in the maternity ward of the Metropolitan Hospital. I will also cite some cases from my practice outside.

When on service here I make it a standing rule that every baby shall be weighed every day, and the weights recorded on weight-charts in the same way that temperature-charts are kept. These weight-charts are posted on the walls of the babies' room, so that the physician or nurse may see at a glance how the little patients are progressing. As soon as a child does not get sufficient nourishment, or becomes ill, the weight will either stand still or diminish.

In a large charity hospital like this one we get all sorts and conditions of people. Many of the mothers are foreigners; some of them cannot speak English; a few are negroes. Some of the babies are born in wedlock, some are not. Nowhere else can such representative figures be obtained.

From the records in my possession I find that the average weight of the newborn babe is 7.46 pounds. The smallest of the series weighed 5.50 pounds, the largest 10.50 pounds. I have occasionally seen these extremes exceeded in private practice. Griffith states that the average weight is 7.50 pounds, but that any child weighing between 6.50 and 10 pounds may be considered of normal weight. Babies weighing beyond these limits may be perfectly developed in every way, and progress in a normal manner after birth.

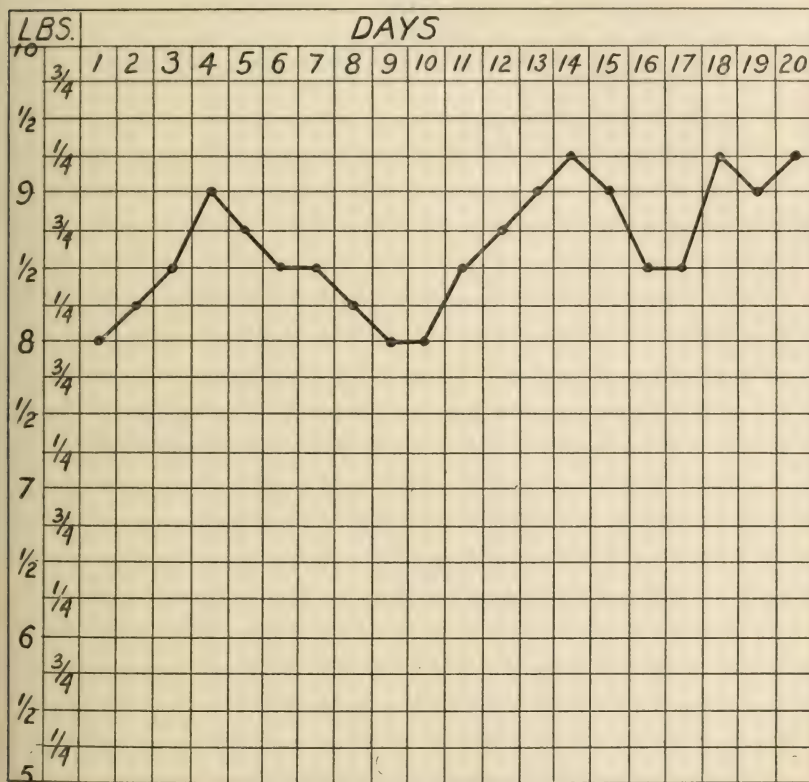
A daily weighing of the infant shows a loss of weight during the first few days. My series shows an average loss of weight

* A clinical lecture delivered to the students of the New York Homœopathic Medical College at the Metropolitan Hospital, January 30, 1901.

for 3.22 days. One baby (Fig. 1) lost no weight at first, but gained a pound in four days. Then it lost for five days, weighing on the ninth day what it did at birth. After that it began to increase in weight again, and went out in good condition at the age of three weeks.

The average loss of weight in the series was .75 of a pound in the well babies—or, approximately, one-tenth of the average

FIG. 1.



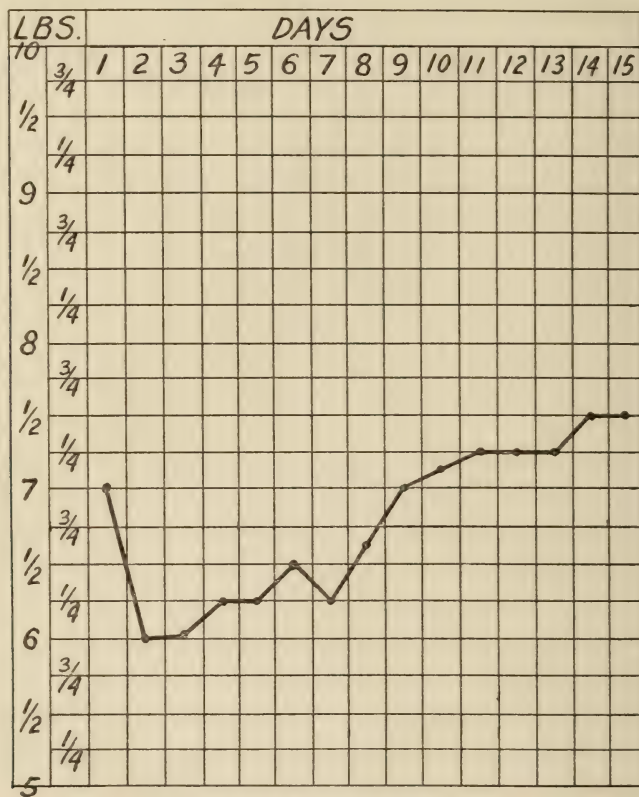
Unusual Curve in Healthy Child.

weight at birth. Just consider for a moment what that means. If an adult should lose one-tenth of the body-weight in a little more than three days, it would probably mean death. In the newborn it is physiological.

The child *in utero* is nourished from the mother by the placental circulation. At the moment of birth this circulation is cut off, and the child has to depend for its subsistence on mate-

rial taken into the digestive organs. The fluid secreted by the breasts of the mother at the time of the birth of the child is watery; it does not contain much nourishment, but it is laxative. When the child is put to breast, the colostrum assists it in emptying the intestines of the meconium. The other emunctories—the skin and kidneys—begin to perform their functions. There is more outgo than income, and the weight falls. (Fig. 2.)

FIG. 2.



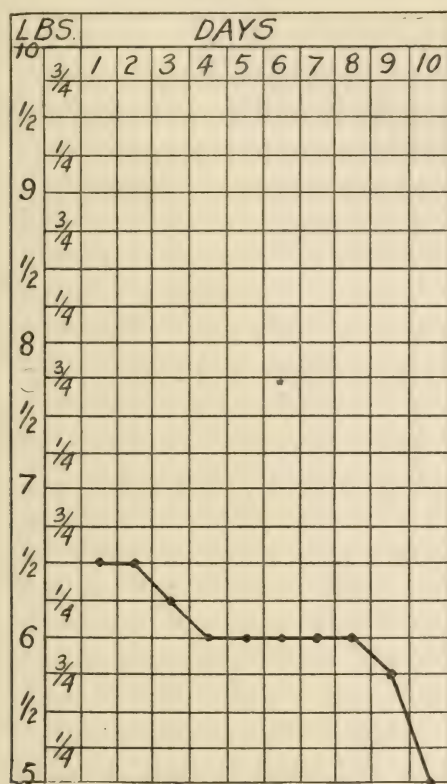
Normal Weight-Chart.

On the third day—sometimes a few hours sooner, or it may be later—the milk begins to form in the breasts of the mother. Immediately the child begins to take on weight, because from now on it receives considerable nourishment. This increase in weight has been found to be more or less constant in the normal infant—so much so that it should double its original weight in six months. During the second six months the increase con-

tinues, and at twelve months it should weigh three times its original weight.

As soon as a baby becomes ill from any cause, its illness is evidenced by either a standstill or a diminution in weight. If the illness is at all serious, the diminution is rapid. This is very well illustrated in the three charts that follow.

FIG. 3.



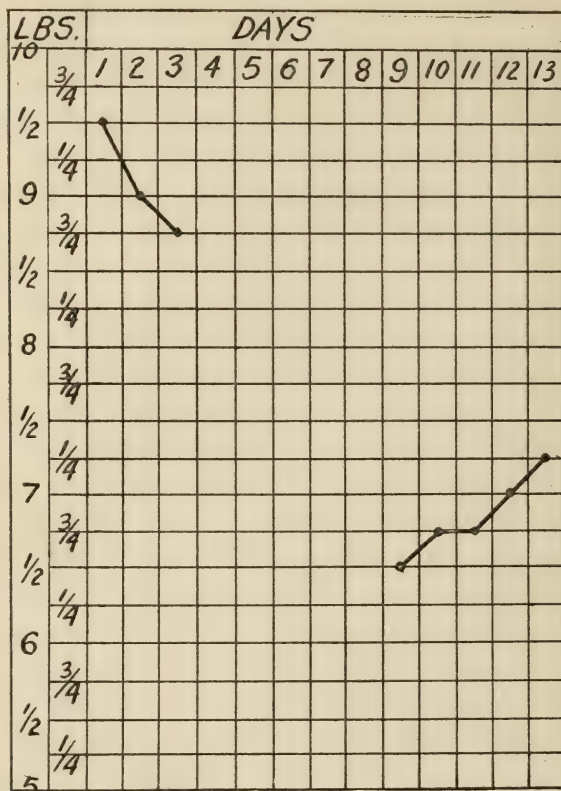
Capillary Bronchitis and Death.

Figure 3 shows the weight-chart of a baby that developed capillary bronchitis and died ten days after birth. For the first two or three days the child was all right. The moment it became ill the weight became stationary. As the child became worse the weight decreased, and at death it had lost a pound and a half.

The next case is that of a baby that developed ophthalmia on the third day. The child was promptly isolated and the

weighing was omitted until the ninth day. At that time the ophthalmia had been cured and the daily weighing began again. The child was nursed throughout, so that its food was not at fault. At birth the baby weighed 9.50 pounds. On the ninth day, after recovery from a mild ophthalmia, it weighed only 6.50 pounds. It left the hospital on the fourteenth day, weighing 7.50 pounds. An increase in weight set in immediately it became well.

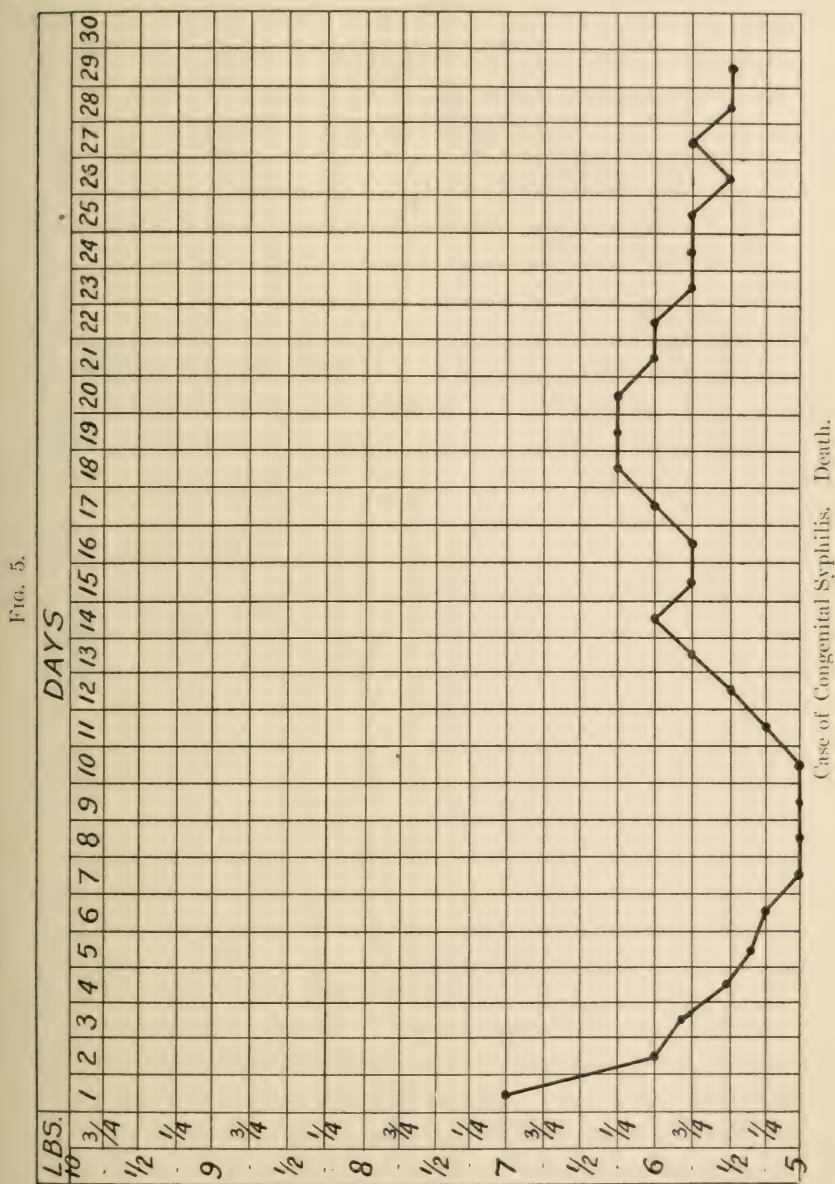
FIG. 4.



Ophthalmia. Weight Not Taken Third to Ninth Day. Recovery.

The last chart that I wish to speak of specially (Fig. 5) is that of a case of congenital syphilis. At birth this baby appeared to be in good condition. The first evidence that it was not was its continued loss of weight for a week. It dropped from 7 pounds to 5. Here it remained for a few days. Then, under forced feeding, the weight gradually improved for a few days. The child died on the twenty-ninth day, after my term of service had ended.

This baby was for awhile unable to retain any food whatever. I finally gave it nothing but somatose in water for a day



or two. This stayed down, and the weight immediately began to increase.

Just here I wish to say a word about a case in private practice that is still under observation. The child was brought to me about the first of November. It was four months old, and had gained but one pound since birth. Its weight, when I first saw it, was 7 pounds. The child was old-looking, its skin was wrinkled, and it had a characteristic musty smell. The mother told me the child was unable to retain any food. It was a bottle baby. I made a diagnosis of marasmus, and gave a doubtful prognosis. The child was brought to me every day, but for a week or more did not improve. I finally put it on somatose and water—nothing else. It got thirty grains of somatose to six ounces of water, and was fed every two hours. That stayed down, and the child began to improve. After three days of the somatose I gave it milk one part, water three parts, with sixty grains of somatose, equally divided, put right in with its other food. The child rapidly increased in weight, and now weighs over 10 pounds. It is plump, the wrinkles are gone, the odor has disappeared. It is a nice, sweet baby, although rather small. The remedy given was *calcarea carbonica*—a drug that is of immense value in marasmus. It received at one time *antimonium tartaricum* for a loose, rattling cough that alarmed me very much for a day or two. In fact, I told the mother I did not believe that in its weakened condition it could survive.

The weight of artificially fed babies does not, as a rule, begin to increase as promptly as does that of babies naturally fed. It usually takes some experimentation to get the right food; meantime the baby is not assimilating sufficient nourishment.

In artificial feeding I have had my best success with the simplest preparations. I use plain cow's milk and water, starting with one part milk and three parts water, increasing the milk as the child grows older. The proportions need to be varied somewhat to suit the case. I give this food without sterilizing. I don't believe in sterilized foods. Of course, the food must be warmed to blood heat when the child takes it, as its natural food is at the body temperature.

Another very efficient food, in my experience, is condensed milk. Condensed milk has several very important advantages. It can be procured anywhere. It is fresh so long as the can is unopened. It can be carried conveniently when traveling, so

that the little patient is not obliged to partake of an entirely different food every time it changes its habitat. Condensed milk is, of course, a sterile food, but the water added to it need not necessarily be boiled.

In closing, just a word about sterilization: If there is any question about the purity of the water or the milk, sterilize it; if there is not, don't. Sterilization takes something, I don't know what—call it vitality, it you like—from milk and water, and babies do not thrive as well on it as they do on the unsterilized food.

REMEDIES FOR OCULAR AND CIRCUM-ORBITAL NEURALGIAS.

BY CHAS. H. HUBBARD, M.D., CHESTER, PA.

(Abstract of a paper read before the Homœopathic Medical Society of Chester, Delaware and Montgomery Counties.)

It is an acknowledged fact that papers upon materia medica, therapeutic indications and allied topics are not popular subjects to introduce to a modern medical society. The demand is for something new, unique or dramatic; not that the profession has lost interest in the *armamentarium* of the new school of medicine, but because no mind can grasp and utilize a long list of abstract symptoms. Some life and a certain degree of continuity must exist to command attention, and unless an essayist presents a well-digested pabulum that can be successfully utilized in relieving pain, eradicating disease, removing a neoplasm or correcting a deformity, he fails to meet the legitimate expectation of his auditors. Hence, with many misgivings, the writer of this paper presents the indications for a few remedies in what is popularly called ciliary neuralgia. Remedies most familiar to the profession will be considered only by way of comparison or differentiation. You are invited to consider a few drugs that are peculiar, unique, or too frequently ignored, but which, from their provings, and substantiated by practical experience, are entitled to the highest consideration. While the etiology, pathology, complications, etc., of this disorder are not considered, and nothing but the nude symptoms are given as a basis for their exhibition, they will often prove themselves promptly curative. When pathology and symptomatology are

happily wedded, the indicated remedy becomes pregnant with the highest attributes of a successful prescription.

Listen to the symptoms of *Amyl nitrite*: Aching pains in the eye, especially the left, due to exposure to intense sunlight. Face flushed (like bell.), but is prone to alternate with paleness and cold face; generally lachrymation and sneezing. Pupils contracted.

Asafœtida.—Sharp, boring pains in or over the eye that seem to begin within and pass outward (aurum pains go from without inward), and are often periodic. Patient desires to be quiet, and makes firm pressure on the eyeball because it gives relief. This remedy has distinguished itself when above symptoms occur during an attack of iritis due to syphilis (*vide* thuja), especially if the patient has been saturated with mercury when it was not clearly indicated, but given empirically, simply because it was a case of syphilis.

Atropia Sulphate.—One involuntarily thinks of dilated pupils, but other symptoms as characteristic claim our attention—intermittent pains that last ten to twenty minutes, and then go away to return again in about the same time. This rapid alternation may continue for several hours, and though the pains are usually in or about the left eye, they frequently run back to the ear.

Badiago should be remembered in intermitting sore pains that seem to be deep in the eyeball, coming on at 3 P.M., and though the patient moves hurriedly about, he jealously guards every independent movement of the eye because it aggravates the pains.

A remedy that is fast carving an imperishable name for itself in supra-orbital neuralgia is *Cedron*. Witness the intense, sharp, shooting pains that usually begin over the left eye at a small point and extend up into the head with *clock-like regularity*, and notwithstanding the pains come and go suddenly, do not think bell. must be substituted. The aggravations occur at night and before a storm. Pains often introduce themselves at 9 A.M., and frequently pass from temple to temple. When malaria complicates the case, it is an especial indication for cedron.

Just here, because of many similarities to the above remedy, it is well to remember our old friend *Spigelia*. Like cedron, it has sharp, shooting pains over the left eye, but they begin in

the occiput and come forward and settle in the supra-orbital region. From thence they appear to radiate from a point and involve the cheek. Resembling cedron, again, the pains are worse before a storm or change of weather, but, unlike the latter remedy, the pains usually begin with the rising of the sun, gradually increasing as the day advances, reaching their acme at noon, when they gradually diminish toward evening. (Nat. mur. has ciliary neuralgia coming on at sunrise, being worse at midday, with much amelioration at sunset.) Another distinguishing feature of spigelia is the extreme tenderness about the supra-orbital foramen.

Hypericum, often called the "arnica of the nerves," is a much neglected drug. In traumatism of the eye or contiguous structures, where there are nerve lesions, it is an invaluable remedy. It will relieve the pains due to old cicatrices resulting from injury or disease. Pains are characterized as sticking, involving the eye and cheek and extending to the vertex, where the pains are intense; sensation as though head would split.

Jaborandi.—The indications for this drug, while not numerous, are unique. There are distressing pains in the eye, and, associated with them, an intense smarting. The affected eyes feel tired, and there is much twitching of the lids. The patient complains that vision changes, now good and now bad. The pupil is contracted. The twitching of the lids suggests agaricus and physostigma, though in agaricus the above symptom is most pronounced, and even the eyeball itself will twitch. It is well to remember that these symptoms are often reflex from the spine, but may be due to decayed teeth or the presence of worms. A peculiarity of physostigma is that patients cannot read or use the eyes for near vision without causing much pain in the eyes, with twitching of the lids. The whole trouble may be due to myopia, when the patient persists in not wearing glasses. Flashes of light and black specks appear before the eyes. While the above remedy will relieve the symptoms complained of, it cannot correct a refractive error.

Onosmodium is another drug that has neuralgic pains, often depending upon eye-strain, worse from any use of the eyes at the near-point. Like many other remedies, the pains usually begin over the left eye (sometimes the pains start over the right eye), extending to left side of the head and passing

around to the occiput and cervical region, aggravated by any movement. Pains usually accompanied by vertigo, the latter symptom often due to otitis media chronica, especially if pains in the ear and around the auricle. With the above indications, if the patient complains of general prostration and acts as though he were born tired and enjoyed being lazy, *onosmodium* has no peer.

Osmium is a remedy no physician should be without. High authority says it has actually cured glaucoma. Of course, it may be indicated in other disorders. Note its pronounced symptoms: violent infra- and supra-orbital pains, with copious lachrymation. Many bright objects, especially the flame of an artificial light, are surrounded by a colored halo. Patient inclined to be very morose, angry and quarrelsome.

Plantago Major.—The indications that give individuality to this drug are the sharp pains in the eye, reflex from decayed teeth, or those depending upon an acute inflammation of the middle ear. The eyeball is very tender to touch.

Prunus is a remedy often indicated and generally ignored. When the pains are so agonizing as to almost dethrone reason; sharp, lightning-like pains through the right eye or the right side of the forehead, and passing through the brain to the occiput, the eye feeling as though it would burst. The patient in his agony will press against the eye and hold it. Pains often circum-orbital, aggravated at night and by motion. There are few, if any, drugs so frequently called for and so promptly curative in ciliary neuralgia as *prunus*.

Terebinthina.—Turpentine has many fields of usefulness outside the paint shop. Think of it when there are sharp pains in and above the right eye; they are so intense that the patient declares he "can't and he won't" stand it. The pains increase as the shades of night fall upon the earth; face is flushed and pupils contracted. If the pains in the back and the urinary symptoms characteristic of this remedy are present, *terebinthina* will not disappoint you.

Thuja.—Not so frequently called for as many other remedies, but when indicated, no other therapeutic agent can usurp its place.

Iodide of potassium or some form of mercury is often prescribed, simply because the pain-racked patient has syphilis;

but such practice is frequently a grave mistake. Note the symptoms: sharp, sticking pains in the eye or eyebrow, aggravated at night, relieved by warmth; globe so tender the patient dreads to eat because the effort of chewing hurts the eye; pains in left frontal eminence disappear from touch.

THE POSSIBLE EFFECTS OF CALCAREO SULPHURICA IN A CASE OF EMPYEMA.

BY O. S. HAINES, M.D., PHILADELPHIA.

IN October, 1898, we admitted to the Hahnemann Hospital a man aged 28 years, a finisher of leather, who had really been a very healthy subject, with the exception of the ailments incident to childhood, until some three weeks previous to his admission. Then he contracted a pleurisy, with an extensive effusion. He laid abed two weeks, worked four days, and was again obliged to go to bed on account of weakness and high temperature. On the evening of the 21st of October he was suddenly seized with a fit of coughing and strangling, during which he was nearly asphyxiated, and expectorated a large amount of pus. He was in such a sad state after this that he was removed to the hospital. An examination of his chest showed that upon the right side, from the inferior angle of the scapula to the bottom of the chest, there was flat percussion sound, no respiratory murmur, no voice transmission, or very feeble. It was also noticed that the heart was displaced towards the left until its apex reached a line drawn downward through the nipple. His expectoration was thick, yellow pus, occasionally blood streaked. It came in gushes, with paroxysmal cough. He would half-fill a spit-cup before relief was obtained. His other symptoms were pallor, weakness, loss of appetite and difficulty of breathing. There were some pains throughout the chest. He was emaciated; for the time, ill. His fever was of a hectic type, temperature reaching 101° at five each afternoon, and falling to normal, with slight sweating, by morning.

It was presumed, from history and signs, that he was suffering from empyema, with fortunate rupture of the abscess into a bronchial tube. Notwithstanding the favorable termination

in such a rupture, we did not feel sure of our prognosis. It is not our custom to treat such cases medicinally, yet he did not seem to be in condition for immediate operation. Attention to diet and careful nursing were ordered. We could not see distinct indications for any remedy, so he was considered a suitable case, clinically, for the *Calcarea Sulphurica*, which was administered in the 3x trituration.

This remedy was continued until his discharge, about the middle of December. We believe, from our examination at that time, that there were, at the time of his leaving the hospital, normal respiratory sounds quite to the base of the affected chest. He looked to be in perfect health, and complained of nothing. We could not help thinking that the remedy participated largely in this brilliant recovery. A recent report from this case confirms what has been said regarding his recovery. It must appear to everyone that neither calc. sulph. nor any other drug will take the place of surgical drainage in those cases urgently demanding the latter, yet the undeveloped possibilities of medicinal therapeutics are many and important. We think the *Calcarea Sulphurica* is a remedy worthy of the attention of surgeons in empyema *after* thoracentesis or drainage at least, even if their nerves will not permit its use before operation.

GASTRALGIA; ITS TREATMENT. — From the Chicago Clinical Society's "Transactions" we cull the following therapeutic hints: Dr. C. F. Barker, when called to attend patients suffering from gastralgic attacks, has found *Dioscorea* and *Magnesium phos.* the most useful of remedies for the pain. But more useful still than either of these, he claims, is *hot water*. Given internally in copious amounts, at the highest temperature that can be borne, this simple remedy is, he says, most efficacious. In a discussion which followed the reading of Dr. Barker's paper, A. L. Blackwood referred to the *Zinc cyan.* as a remedy that would, perhaps, be needed to meet the neurosis that underlies so many cases of gastralgia. He also spoke favorably of *Nux vom.* for such cases as depend upon an excessive use of tea, coffee, tobacco, alcohol, or where worry, anxiety or mental exhaustion is present. *Ignatia* and *Argentum nit.* were to be remembered for women who are easily disturbed, and who present the characteristic symptoms calling for these remedies. In cases resisting all other forms of treatment, the last speaker recommended as anodynes one-fourth of a grain of codein phosphate given hypodermatically, or chloroform water, one teaspoonful given every ten minutes until relief was obtained. — *The Clinique.*

EDITORIAL.

HOMŒOPATHY AND MEDICAL SCIENCE.

APROPOS of our editorial in the March number of this journal in reference to the fact that it was not to be expected of homœopaths to distinguish themselves by contributions to so-called "scientific medicine," we came across a grandiloquent little squib in the correspondence of the *International Medical Magazine* of Feb., 1901, entitled "Arraignment of Homœopathy." In it the verdict arrived at is given in startling italics, as follows: "*One hundred years of Homœopathy* and NOTHING DONE—NOTHING." After reference to "a veritable Jacob's ladder of achievements" (in the allopathic school), "up and down which the angels of Love, Life and Wisdom might love to travel" (this "werges on the poetical," we think, as Sam Weller would say), the proud author closes his laudation with the climax, "Our achievements are our glory."

It does not strike us that this last achievement of his is a peculiarly glorious one. Let us see: In collecting material for an address which he was to deliver, he became "impressed with the fact that in spite of the large number of homœopathic doctors among us, and of the existence of their school of medicine for a hundred years, he could not discover that anyone belonging to this persuasion had contributed anything of the least importance to the progress of scientific medicine."

Naturally, "being afraid openly to make such a statement with information derived only from a general review of their literature," he wrote first to one homœopathic physician, an acquaintance of his, asking "what the homœopaths had done during the last century." He was referred by his friend to the editor of "one of the first homœopathic journals," of whom he requested "a synopsis of the important contributions to general medical science made by homœopathic physicians dur-

ing the last hundred years." It was suggested that he write to a certain librarian. This he did, "hoping for a lengthy reply." But he received no reply, either long or short, and he at once concluded that said librarian "had nothing to say," and that, therefore, "no better illustration of sterility of thought and impeded progress" (presumably in homœopathy, and not in said librarian) could be found. This is his argument, and upon it he founds the verdict pronounced above. In the first place, his review of homœopathic literature must, indeed, have been general and limited in extent if he failed to recognize the importance of Hahnemann's own contributions to "general medical science." Let him contrast the treatment of disease by his own school before and during Hahnemann's time with that prevailing ever since. That the remarkable change has been in a great measure due to the influence of homœopathy is universally acknowledged by all acquainted with medical history. Is the introduction of new remedies to be applied according to a new fixed principle no contribution to medical science? We think that those gentlemen of his own school who, a few years since, with much *éclat*, announced their discovery of the efficacy of rhus in rheumatism—a fact long before their time to be found in every homœopathic primer—would not be flattered by such an assertion. Does our author mean to exclude therapeutics from the domain of general medical science? We think not, for along with hæmostatic forceps, and various ligatures and sutures, he mentions also the serum therapy of Behring as among the achievements of which he boasts. Homœopathy is the science of therapeutics, and in that field of general medical science its achievements are to be sought, and there they will also be found. We do not find fault with oculists for not inventing some new coal-tar product, nor is it an illustration of sterility of thought and impeded progress that they have nothing to say about new operations or new instruments designed for gynecologists. *Non omnes omnia possumus*. Homœopathy is a specialty, and its achievements are to be looked for only in its legitimate domain. But aside from this, which is in itself, in our opinion, enough to show the inanity of the sweeping denunciation of homœopathy by the author of this arraignment, there are other allied considerations which deserve attention.

By whom has the progress in therapeutics in the old school

been made? Let the mass of literature daily flooding our offices from the pharmaceutical chemists give answer. They, and not the active practitioners of the allopathic school, are the leaders in therapeutics. The thousand and one new remedies for the cure of disease are not the result of the study and thought and experience of active clinicians, but the suggestions of manufacturing chemists, supported by "unsolicited testimony" as to their efficacy by the indolent or ignorant of the profession. That here and there most valuable remedies are produced is without question; but this cannot be credited to the medical profession. On the contrary, the very fact of the ready acceptance accorded to almost any new product "made in Germany," to the exclusion of the well-known and oft-tried remedies, seems to us a forcible illustration of sterility of thought and impeded progress.

Further, is the principle enunciated first by Hahnemann, and since his time universally acknowledged, that the only way to test the effects of drugs is by "provings" on the healthy, no contribution to general medical science? Are the provings of newer remedies by later homœopaths of no value? Are the empirical uses, for example, of nitro-glycerine and of the snake poisons to be regarded as more valuable contributions to medicine than the application of Glonoin and Lachesis, Crotalus and Naja, according to a well-defined law?

Again, it is rare to find, even among the builders of that Jacob's ladder so poetically described by our author, the real clinicians. Even in the allopathic school, the boasted achievements were in the line of specialties, and by specialists; and had our author gone a little more thoroughly into homœopathic literature he would have found contributions to medical science by our specialists also, in the way of new operations, new instruments, new modifications of anæsthetics, and even new theories and extensive practical applications thereof. Were the homœopaths as eager and as persistent as their allopathic brethren in trumpeting abroad every deviation from routine procedure as a new discovery, and every half-digested and wholly unsubstantiated theory as an epoch-making revelation, and were our journals read by them as universally as theirs are by us, there would be less apparent grounds for accusing us of sterility of thought and impeded progress. We homœopaths,

in order to become acquainted with general medical science, are willing to wade through allopathic literature (in addition to reading our own), while to the mass of old-school practitioners homœopathic literature, representing as it does the most important section of general medical science, viz., therapeutics, is an unknown quantity, neglected X-rays. In order, therefore, to bring any subject before the whole medical profession, it is still found necessary by some to seek to have it appear in an allopathic journal, a course which, theoretically, is open to serious objection, but which, practically, would redound to the honor and credit of our school if the author presenting such subject was courageous enough, and the journal liberal enough, to acknowledge its homœopathic source.

Finally, let us take heart and comfort ourselves with the thought that, even if homœopathy has done nothing for so-called medical science, it has been of incalculable benefit to suffering humanity; that here quality, not quantity; permanent brilliancy, not ephemeral scintillation; utility, not glamor, are the tests of the value of achievements. Our achievements are our glory, too, and long after very many of the present boasted achievements have been forgotten, and their memory only preserved in journalistic epitaphs, Homœopathy, with its principles and progress, will still continue to influence true medical science.

RICHFIELD SPRINGS AND SOME INSTITUTE MATTERS.

As announced in the *HAHNEMANNIAN MONTHLY* for March, the postal-card vote ordered by the Executive Committee of the American Institute of Homœopathy resulted in the selection of Richfield Springs as the place for holding the next annual session of our National Society. While we do not approve—nor will others approve, when all the facts are made known—of the methods used to bring about this result, nevertheless Richfield Springs stands as the latest choice of the Institute, and we abide cheerfully by the result, just as we believe the 27 present at the Saturday session in Washington should have re-

frained from any antagonism to the Institute's wish expressed at its liberally attended Thursday morning session, and just as the Executive Committee should have respected the expressed wishes of the majority of members present at the last annual session. However, that is a by-gone, and now we are for Richfield Springs. This place is the fortunate possessor of some good hotels, and, like all places thus provided, is well supplied with attractions. Many will be disappointed at the failure of Niagara Falls to win the election, as they were desirous of attending both Institute sessions and the Pan-American Exposition. To them we say, Go to Richfield Springs and attend the meeting; Buffalo is but three hours distant, and can be visited either before or after the Institute meeting with but little inconvenience and very little additional expense over that incurred had the sessions been held at Niagara as ordered by the Institute at Washington. We find, also, that Richfield Springs is possessed of many side-attractions to amuse those who find the essays and debates tiresome. Thus, the Executive Committee promises golf, driving, and loafing in groups of two or more under the shady elms. True, they are not as grand as Niagara attractions, but nevertheless they are attractions.

In a communication to the profession, bearing date of January 1, 1901, and signed by the President and General Secretary, it is stated that the Executive Committee will discountenance trolley rides, excursions and other worldly pleasures by daylight. To this end, the scientific programme has been limited to the day hours, leaving the evenings for recreation. We were very sorry to see this notice. Several years ago it was customary for the Institute to hold evening sessions, and the sections which secured these hours for their deliberations considered themselves fortunate, as they were always well attended. Of late numerous reunions, receptions and other functions have been added to the programme, and, according to our ideas, to the disadvantage of the Institute. Should scientific meetings be held in the evenings, and the social functions in the evening be limited as of yore to but one, there will be no necessity for prolonging the annual session beyond Friday morning. More men will remain until the end, and there will be less chance for sneak legislation with but a corporal's guard of members present.

CONCERNING MEDICAL CANDIDATES.

THERE seems to be a general tendency among physicians of all schools of medicine to criticise adversely the character of men selected to fill high offices in their several societies. Such a tendency is decidedly detrimental to the interests of medical organizations and greatly impairs their spheres of usefulness. Before accepting as true the charges so freely and publicly made, it is well to remember that there are on hand in all organizations certain men who are chronic malcontents, invariably against the administration. Unfortunately, however, we find arrayed among the critics many physicians of the highest motives and of sound judgment; men, moreover, who are above envy and deceit. This being the case, the criticism of medical politics must be based upon some truth. Up to within a comparatively few years it was the custom to present as candidates men who were regarded as representative medical men. The office sought the man, and in turn the man dignified the office. But things seem to have changed. Presidential and other booms are started on what? The desire of some particular man to have office. His friends are made acquainted with his ambition, and, inasmuch as opposing candidates are no better—they may possibly be worse—start the boom a booming, and the campaign is on. Under such circumstances it is impossible to secure an ideal candidate, for he can have no chance of winning. He will not have his friends electioneer, and he cannot afford to be beaten at the polls by his inferior in reputation and ability. The self-aspiring candidate may be but a buccaneer, in that he has but recently joined the society and attended but few of its meetings; but that makes no difference; he wants to be president.

We have referred to the presidential office only; but the secretaryship should also come in for criticism. In the vast majority of cases secretaries are elected for work, and not for honor. Nevertheless, a good secretary soon succeeds in controlling all society legislation and shaping the results of elections. He above all others should therefore keep himself free from politics and electioneering schemes. His experience and

knowledge of the profession will, of course, make him invaluable as an adviser, and this gives us an additional reason why his conduct should be invariably above suspicion. As soon as he enters into political combinations, just that soon he becomes a menace to the society's welfare. He, more than any one else, can make himself responsible for the character of other candidates.

Just why certain men like to manœuvre for office we cannot say. An election is to be appreciated when it comes without asking; but it is otherwise when it is gained by intrigue and politics. We presume it is for the same reason that certain other men are willing to win a game of cards by cheating; they know in their own hearts that they do not deserve the game, but the other fellows think they are beaten, and that affords a selfish pleasure to the so-called winners.

We have often thought that the desire to parade before the public in presidential garb has something to do with these unholy ambitions. In support of this suspicion, we find that it is the custom of some society officials to use the official paper of the organization in all their correspondence—professional and lay. We have often wondered why this was permitted, but it seems to find no public critics. It is high time that it should meet with formal condemnation.

ON THE ACTION OF EUPHTHALMIN UPON THE EYE.—Experimental investigations from the eye clinic of Prof. Belljarminow, St. Petersburg: a 5 per cent. solution was recommended, which gave almost the same results as 10 per cent., but of shorter duration (one and a half hours less). The *resumé* of his investigations is:

1. Mydriasis sets in quite readily.
2. Its duration is short in comparison to other mydriatics.
3. Paresis of accommodation is slight.
4. The intraocular pressure is not increased. (In chronic glaucoma it may bring on an acute attack of inflammatory glaucoma, as recently observed by H. Knapp.)
5. The epithelium of the cornea remains intact.
6. No symptoms of irritation or general intoxication occur. All these advantages secure to euphtalmin a prominent place in ophthalmologic practice.—I. Woskressensky, *Wochenschrift für Therapie und Hygiene*.

GLEANINGS.

TYPHOID FEVER WITHOUT INTESTINAL LESIONS.—At a meeting of the Johns Hopkins Hospital Medical Society, Dr. Opie stated that in a certain proportion of cases of typhoid fever no lesions of either large or small intestine are found at autopsy, and recently a case apparently of this kind had come under his observation. The patient, a child of ten, presented a characteristic typhoid history, with typical rose spots on the abdomen and a positive agglutination reaction. The disease appeared to be mild, and the temperature ranged from 102° to 104° during the first week. On the thirteenth day after admission nose-bleeding first began, and purpuric spots appeared on the face. The bleeding was difficult to control at times, and on the seventeenth day after admission she passed 60 c.c. of bright red blood from the rectum. Two days later, purpuric spots appeared over the face, neck, front and back of chest, and posterior surface of the arms. On the twenty-first day after admission (the twenty-sixth day of illness) bleeding from the nose became uncontrollable, and she died. The blood-count, which had previously been that of a symptomatic anæmia, on the day of death showed a leucocytosis of 15,000. The coagulation time of the blood, tested by Wright's coagulation tubes, was first $4\frac{1}{2}$ and finally $5\frac{1}{2}$ minutes. The findings at autopsy included minute ecchymotic areas in heart-muscle, lungs, liver, kidneys and stomach; Peyer's patches and solitary glands were visible; the retro-peritoneal and mesenteric glands were enlarged; and while section through several Peyer's patches showed no hyperplasia, groups of large epithelioid cells similar to those constantly found in typhoid lesions were seen. A motile organism corresponding to the typhoid bacillus was obtained by culture. Notwithstanding the slight intestinal lesions, Dr. Opie thought this was a case of hæmorrhagic typhoid. He reviewed the reported cases of typhoid without intestinal lesions, and said he could find no conclusive proof that the infection could occur without some slight lesion of the intestinal tract.

In discussion, Dr. Fletcher said that this was the second case of hæmorrhagic typhoid out of more than a thousand cases of that disease treated at the Hopkins Hospital. Dr. Welch remarked that there was no question that cases of typhoid could occur without ulceration of the intestine; the history of some mild cases would lead one to suspect infiltration of Peyer's patches and the solitary follicles without actual ulceration.—*Phila. Med. Journ.*, Jan. 19, 1901.

F. Mortimer Lawrence, M.D.

THE CLINICAL VARIETIES OF BRIGHT'S DISEASE.—Bradford, of London, summarizes his views as follows:

1. We may recognize two forms of acute Bright's disease, one characterized not only by the well-known urinary changes, but also by the presence of dropsy; the other where dropsy is absent, and where the distinction between the acute Bright's disease and mere congestion of the kidney is by no means easy.

2. There are at least two forms of chronic Bright's disease—one where the patient secretes a scanty, highly albuminous urine, and becomes markedly dropsical, the course of the malady being chronic, and death occurring usually from the mere water-logging of the tissues or from the development of inflammatory complications, or from chronic or subacute uræmia. The second form of Bright's disease, where the symptoms often run a latent course for an unknown period, and where the patient seeks advice on account of very vague symptoms of ill-health, such as wasting, loss of strength, circulatory disturbance, or even where he does not seek advice until the onset of acute and fatal uræmia. In this form of the disease dropsy is absent, the urine is abundant and pale, and it contains a considerable quantity of albumin. It would seem that not only may chronic Bright's disease be chronic from the outset, but also that the two varieties of chronic Bright's disease are not necessarily different stages in the same morbid process, but represent rather the different effects of perhaps the same morbid process.—*Lancet*, Jan. 5, 1901.

F. Mortimer Lawrence, M.D.

CLEARING OF OPACITIES OF THE CORNEA.—Prof. Ernst Fuchs, of Vienna, observed in old corneal scars (after eczematous keratitis) fine transparent lines, which appeared black on bluish-white grounds, while blood-vessels represent very fine gray lines in direct light, which become dark in transmitted light; also the ramifications of both are different. He supposes that this kind of clearing occurs only in eyes which still grow after cicatrization took place. The growth of the cornea is interstitial in such a way that new-formed fibres enter between the fibrillæ of the cornea. Since also the opaque portions of the cornea participate in the growing process, new and consequently transparent fibres arise in them, which appear as bright lines on opaque ground.

The experimental proof, studied by him on rabbits, yielded, however, negative results. As to the position of the scars in the cornea, they could be shown to separate, but only in the same proportion in which the surface of the cornea grew, and their situation to each other as well as to the centre and periphery of the cornea remained unaltered. A cornea with opacities which, e.g., had grown a third within three months, looked as if magnified by a third through a lens. Thus he concludes that the growth of the cornea in all its parts is equal. A rotation of the eyes around a sagittal axis, while growing, could be excluded. The observations of Fuchs do not accord with the supposition of Knies, that the cornea chiefly grows from the centre toward the periphery.—*Beiträge Zur Augenheilkunde*.

William Spencer, M.D.

REMARKS UPON THE TREATMENT OF GONORRHOEAL OPHTHALMIA.—The author discusses five points in the treatment of this disease:

1. Shall ice be used, and in what form? If the patient is seen soon after infection a few drops of either a 2 per cent. solution of nitrate of silver or a 20 per cent. protargol solution is instilled into the eye, and then a clean piece of ice should be laid in 100 grammes of water containing two drops of formalin. After dipping a small piece of linen or cotton pad into the solution it can be laid on the ice, and from here placed on the eye. An ice-bag is contraindicated, since such weight would interfere with the movement of the lids.

2. As to the use of nitrate of silver and protargol: If the conjunctiva is free of membrane it would be better to commence with silver nitrate, and unless positive improvement sets in at once, protargol must be employed (nitrate of silver 2 per cent. and protargol 20 per cent.).

3. How shall pus be removed from the eye? He uses very weak solutions of formalin, so weak indeed that they cause no pain. He generally uses a 6 per cent. borax solution to which is added a little salt, and to this is added the formalin solution of the strength mentioned above. With this solution the conjunctiva is irrigated every fifteen minutes so long as there is any secretion. Of course great care must be taken not to touch the cornea and conjunctiva, and if necessary the patient must forego sleep in order to prevent the accumulation of the secretion between the lids.

4. As regards protecting the good eye. This should always be done after the manner familiar to us all, an occlusive bandage being employed. The edges of a piece of borated lint are smeared with glycerin-gelatin, laid over the eye, and the edges made adherent with collodion. The patient is then compelled to keep his diseased eye open in order to see.

5. General treatment: This consists in keeping the bowels open; fresh air and nourishing diet are also important aids. He has seen benefit follow the internal administration of iodide of potash. But from the standpoint of the homœopath we must not forget that even though we are using the nitrate of silver solution topically, the same remedy potentized is the most frequently indicated remedy in the whole materia medica for any form of purulent inflammation of the conjunctiva.—Dr. Wolfberg, Breslau, *Wochensch. f. Therap. u. Hygiene des Auges*.

William Spencer, M.D.

TREATMENT OF HEART AFFECTIONS.—H. A. Hare, M.D.: In writing on the heart remedies, digitalis is placed at the head. It is considered one of the best, as well as one of the most abused, remedies at hand. The great mistake made in those giving digitalis in heart affection is that it is not combined with rest. This is considered as of the utmost importance. If rest is first resorted to, and the areas of cardiac dulness studied, and later digitalis given, a definite idea can be reached as to the value of each.

The use of massage is of value in the treatment of heart affections, for there can be no doubt that the active and passive movements of the muscles stimulate the circulation and prevent capillary stasis. It is not only unwise, but foolish, for patients with weak hearts to take large quantities of food and liquids at a time, not only on account of impediment to the circulation, but also on account of the interference of the heart's action by reason of the pressure exerted.

The value of digitalis in any case is to increase the nutrition of the heart-muscle. The drug has a cumulative action, therefore its use is advised in moderate doses. The effect from large doses of the drug is first a temporary improvement, then the heart begins to loose at a great rate, and soon is in a worse condition than before, owing to the incoördination of the ventricles and imperfect systolic contraction. If the lesion be a valvular one, it is made worse. It should not be given too frequently, and never be used if the tension be high. It is contraindicated in fatty degeneration, for in such cases there is an absence of the normal heart-muscle for the drug to act on. It is also contraindicated in aortic regurgitation and in gastric disturbances.

Passing from this drug, we come to the next one, *strophanthus*. It is to be preferred before *digitalis* when a high state of vascular tension is present. Unlike *digitalis*, it is given in too small doses, and when the time comes for it to be used in large doses, it produces an irritation of the bowels. Finally, it is better in children than *digitalis*.—*Therapeutic Gazette*, Jan. 15, 1901.

William F. Baker, A.M., M.D.

AUTO-INTOXICATION FROM RENAL INSUFFICIENCY, WITH OR WITHOUT DISEASE IN THE KIDNEY.—It is advised that the urinary output of all patients coming under the care of physicians should be examined. The writer says: "I wish to assure you that it has been a revelation to me, and the therapeutics based on the results of these examinations have been marvelous in their results. Uræmia is generally considered a result of kidney disease, but the results of these observations tend to show that it may occur in persons with sound kidneys. The amount of urinary solids should bear a relation to the body-weight. A man of 40 years of age and weighing 160 pounds should pass 1168 grs. of urinary solids daily, and if, by actual measurement, only 500 grs. be passed, what has become of the remainder? If this continue, what happens? A condition of uricacidæmia sets in, manifesting itself by vertigo, arterio-sclerosis, sick-headache, melancholia, epilepsy, or even insanity.

Practically all diseases of middle life, not infectious, are the result of faulty metabolism and elimination.

An easy method of determining the total solids is to collect the entire amount of urine for twenty-four hours. Take the specific gravity and multiply the last two figures by the number of ounces, and to this add 10 per cent. Another method is Haeser's coefficient, 2.33, with which we multiply the last two figures of specific gravity, and this will give us the result of 1000 c.c., and from this the total may be calculated.

The attention is called to the part that the salts of potash play in urinary intoxication. No person suffering from defective urinary elimination should have any salt of potash under any circumstances. Bouchard says that where the excretion of urine falls to one-half or two-thirds of what it ought to be, there is produced in the organism an accumulation of mineral substances, particularly potassium. We know that in uræmia there may be a preponderance of action of potash which may be two-thirds of toxicity instead of one-third. Cases are mentioned in which, as the result of the administration of potash salts, uræmia was precipitated.—*N. Y. Med. Journ.*, Feb. 9, 1901.

William F. Baker, A.M., M.D.

HYSTERIA AND HYPNOTISM.—Dr. Crocq, of Brussels, presented the question of the affinity between hysteria and hypnotism before the International Congress of Medicine meeting at Paris during the summer of 1900. He claims, with the school of Nancy, that hysteria and hypnotism are two distinct and separate conditions; that hysteria is a pathological phenomenon, while hypnotism is a truly physiological phenomenon. He takes issue with Charcot, Richer, Gilles de la Tourette and Babinski, that hypnotism is a pathological condition derived directly from hysteria. Gilles de la Tourette, in a work recently produced, proclaims hypnotism as an hysterical paroxysm.

Valentine, a pupil of Bernheim of the school of Nancy, has lately asserted his belief with Gilles de la Tourette. Dr. Crocq claims that a careful and impartial examination of the facts proves hypnosis to be a physiological phenomenon, the explanation of which is found in the knowledge of psychological automatism, and gives no key to the mysterious phenomena of spiritualism and occultism. All the methods extolled for the provoking of hypnosis have for their object the fixation of the attention; the chilling of the imagination; the separation of the higher psychical centres. The individual in whom the higher psychical centres are profoundly separated, more or less numbed, necessarily presents a functional disassociation of the nerve centres; the higher centres lose to a more or less marked degree their control over the automatic centres. The more complete the separation, the more accentuated the anomaly, the more profound the hypnosis. He therefore defines hypnosis as a condition that essentially consists of a functional disassociation produced in the nervous centres, having for its object the more or less marked separation of the conscious and higher psychic centres. Hysteria, on the contrary, is a pathological phenomenon, and the functional disassociation, while similar to that of hypnotism, is spontaneous. Hypnotism being a physiological phenomenon and hysteria pathological, the former cannot be considered as a manifestation of the latter. Those capable of being hypnotized are not necessarily hysterics. There exists, however, between the two conditions a relationship characterized by a hyper-suggestibility more or less marked, and responding to similar psychic formula. Let I represent the degree of impressionability and R the degree of resistance to suggestion, and they would stand in relation to each other, in a normal subject, as two to four. The formula is written thus: $I : R = 2 : 4$. Then follows a series of formulæ representing the variations in these states found in different subjects.

Hypnotism can produce in normal subjects states of suggestibility equally as profound as can be produced by hysteria in the pathological subject. The subjects will be able to present under hypnosis the psychic formulæ analogous to those which belong spontaneously to hysteria. From this can be understood why the suggestibility grows with the degree of profoundness of the sleep.

Exceptions prove the rule. Certain subjects present a hyper-suggestibility contrasting with the light sleep, in whom the psychic formula in a state of somnolence is not normal, and reflected a hyper-impressionability or a hyper-resistance. Others present a hypo-suggestibility contrasting with the profound sleep, in whom the automatic centres, long educated by the powerful higher centres, are supplied with functions momentarily after separation from the latter. The hysterical hyper-suggestibility produces either an exaggerated hypnotability or a greater resistance against hypnosis, according as the auto-suggestions of the subject are favorable or not to hypnotization, and according as the attention is more or less easily fixed.—*Le Progrès Medical*.

John J. Tuller, M.D.

THE TREATMENT OF OCCIPITO-POSTERIOR POSITIONS OF THE VERTEX.—Broadhead endorses the statement of Reynolds, that before labor has begun, where the membranes are intact and engagement has not taken place, the patient should be placed twice a day in the knee-chest position, for the last two weeks of pregnancy, and then in the lateral position. It is claimed that

by this method the position will be almost surely an anterior one. In the choice between forceps and version, in cases of persistent occipito-posterior position above the brim, each operator should be governed by his individual experience in operative obstetrics. No rule can be laid down in these cases for the one or the other method of treatment, nor can it be said that either method of treatment is inadmissible in all cases. It is his opinion that for men of small operative experience version, not only in occipito-posterior, but in occipito-anterior positions as well, is a safer operation for the mother than high forceps. The foetal mortality, on the other hand, will be higher with version than with forceps rightly used. With reference to the internal manual rotation of the occiput forwards, prior to the application of forceps, it can be said that, in the hands of men accustomed to intra-uterine manipulation, the occiput in some instances can be rotated forwards, but that in many cases, especially those in which the membranes have been ruptured for some hours, the operation is difficult, and in cases where the head is grasped firmly by the lower segment of the uterus, which may have been thinned by protracted labor, even dangerous. In the latter class of cases, forceps carefully used would be safer than version, even in the hands of men of comparatively small experience.

For operators of considerable experience, possessed of the proper knowledge of the technique of the high forceps operation, the following plan is recommended: An attempt should be made, first under deep anaesthesia, to rotate the occiput to the front by the introduction of the hand into the uterine cavity. Failing in this, forceps should be applied to the head in the posterior position by the so-called pelvic application, and the head extracted as described below. The high forceps operation in these cases, as in all others, is always to be undertaken with a proper appreciation of its difficulties and dangers. Nevertheless, in careful hands and with normal conditions, he believes that the forceps in posterior as well as in anterior positions above the brim will give better results than version, as far as the child is concerned, and results equally good for the mother. Failing to deliver by forceps, the child being alive, version is the other alternative. For men who are uncertain as to their ability to conduct the high forceps operation correctly, and whose experience is small, version is much the safer operation, and is to be advised. But even here, in case there is but little amniotic fluid left and the uterus is tightly contracted about the foetus, the careful, tentative use of the forceps is to be preferred to internal podalic version. Very little difficulty may be experienced with forceps, whereas version might result in a rupture of the uterus.

The second class of cases includes those in which the vertex is engaged in the brim or is in the pelvic cavity, but is not yet at the pelvic outlet. In many of these cases the failure of the head to rotate and advance seems to be caused by imperfect flexion. During each pain, therefore, the forehead may be pushed upward in order to increase flexion and bring the occiput lower down. Should further assistance be indicated, the forceps is to be used. If the vertex is merely engaged, the blades are applied at the sides of the head by the so-called pelvic application, the head being grasped, as a rule, somewhat obliquely. If the head is in the pelvic cavity, the blades should be applied directly to the sides of the head, the so-called cephalic application being made. Traction should then be made in the proper axis until the vertex is brought to the pelvic outlet. Should the occiput rotate

anteriorly during the operation, as is frequently the case where the position at the beginning of the operation is more nearly transverse than posterior, the treatment becomes that of the normal position.

If the occiput remains in posterior position when the vertex has reached the outlet, further treatment of the case should be the same as for those cases which comprise the third class of our subdivision—namely, persistent occipito-posterior position at the outlet, on the perineum. In this last class of cases rotation of the head forwards with the forceps is advised if the conditions are favorable. Tucker's forceps are preferred on account of the solid, unfenestrated blade.

The favorable conditions are: good flexion, vertex low down or on the perineum, membranes ruptured, cervix fully dilated or dilatable, bladder and rectum empty, and the operator positive in his diagnosis of the position.

After the usual antiseptic precautions the blades are introduced at the sides of the pelvis, each blade being rotated so as to occupy a position at the side of the head, after which the forceps is locked. He believes that it is safer to apply the forceps in the usual manner (the concavity of the pelvic curve looking forward) than to attempt the rotation with the forceps in the inverted position, but in the hands of an expert the latter method might be used safely. Laceration of the soft parts can be avoided to a great extent if, during rotation, the handles of the forceps are carried well out towards the thighs, thus describing a segment of a circle with the handles of the forceps in proportion to the pelvic curve of the instrument. By this means the blades occupy the same position in the center of the pelvis, and have the action of straight forceps, which are preferable to curved. Two fingers of the operator are placed upon the vertex, preferably on the sagittal suture, and kept there during the operation, in order to note whether the head is turning with the blades or whether the blades alone are being rotated. The handles of the forceps are seized with the other hand and the blades held firmly against the child's head. The fingers of the one hand being kept in position on the sagittal suture, the head is rotated during a contraction from a posterior to a transverse position by rotating the handles of the forceps, at the same time carrying the handles of the forceps downward and backward until the cavity of the pelvic curve faces the lateral wall of the pelvis. The head is then held in this position for several moments, until several contractions and relaxations of the uterus have taken place. During the relaxed periods the back will usually rotate forwards. The head is then rotated to the R. O. A. or L. O. A. position, as the case may be, by rotating the handles still further backward and downward. By so doing the tips of the blades are kept constantly in the middle of the pelvis, and therefore cannot lacerate the vagina. The head is held in the oblique anterior position for several minutes more, in order to allow the body, during a relaxed condition of the uterus between its contractions, to rotate anteriorly, to accommodate itself to the position in which the head is held.

The rotation of the body can be confirmed by palpation and auscultation, and by the fact that after the blades are removed the position will remain anterior. After such a rotation it is surprising to note the advance which often takes place immediately after the occiput has come to the front, and in many cases, when once the head has been turned to the transverse position,

the rest of the rotation is spontaneous and delivery is easily accomplished. After the removal of the blades the rest of the delivery may be left to the natural forces, but as a rule it is better to reapply the blades in the usual manner and complete the operation in the usual way. If rotation takes place, as it usually does, much has been gained, especially in primipara; but if the rotation cannot be accomplished except by the use of force, the head should be extracted in the posterior position, the forehead being brought under the pubic arch and the head made to advance by using traction in such a way as to promote flexion. When it is evident that delivery can be accomplished by the natural forces, the forceps are removed and the patient delivered in the usual manner.—*American Journal of Obstetrics*, December, 1900.

George R. Southwick, M.D.

MASSAGE IN GYNÆCOLOGY.—(Olshausen.)—The writer states that while he does not positively oppose the use of massage in all cases, he is of the opinion that it is a remedy of limited application. It is used too often in unsuitable cases, and often to the harm of the patient. He is especially opposed to the use of massage for the treatment of retroflexion and prolapsus of the uterus, with the exception of a few cases of fixation of the uterus, in which massage has a very limited application. Recent retroflexions of the puerperal uterus can be treated to advantage by manual reposition of the uterus into ante flexion and thorough massage of it. With the exception of the few cases noted, massage of the uterus is of no value in the treatment of uterine displacements.

Massage is only suited to the treatment of old exudates in the connective tissue of the pelvis after all signs of inflammation have disappeared for a long time. Only such exudates should be treated by massage as are easily accessible to the external hand, so that nothing lies between the exudate and the tips of the fingers except the abdominal wall.

Tubal tumors are very seldom to be treated by massage except cases of hydrosalpinx, in which the fluid can be made to discharge through the uterus. Massage of tubes with thickened walls and without fluid contents is sometimes followed by improvement of the surrounding infiltration.

Peritoneal adhesions, hæmatocœles, malpositions of the vagina or of the uterus are not objects for massage, although they can be benefited indirectly in some cases by the massage of circumscribed exudates.—*Centralblatt für Gynækologie*, No. 3, 1901.

George R. Southwick, M.D.

EXTERNAL VERSION FOR THE TREATMENT OF TRANSVERSE AND BREECH PRESENTATIONS.—Henri Varnier, in his recent work on "La Pratique des Accouchements," recommends that transverse and breech presentations of the child should be converted by external manipulations into vertex positions previous to labor. He finds Pinard's "ceinture eutocique" to keep the child in position as necessary in the accoucheur's armamentarium as the forceps or the embryotome. In 6000 labors, from 1885 to 1897, there was not a single case of shoulder presentation in the clinic, as the presentation was corrected nine times at the beginning of labor and nineteen times in the last month of pregnancy.

Forceps are applied in the clinic of Baudeloque in 2.3 per cent. of the cases. It is admitted that in private practice forceps are applied if the child is not

delivered in four hours after the cervix is fully dilated; the forceps are usually applied earlier in the clinic. Forceps at the brim in normal pelvis are very seldom used and generally to be condemned.

In occipito-posterior positions the entire hand is introduced, and with the aid of one blade of the forceps the occiput is rotated toward the transverse diameter and side of the pelvis to which it points.

Varnier warns against the premature use of the catheter in the puerperal state, and has never seen harm to follow waiting patiently, if necessary, thirty-six hours after labor, before using the catheter.—*Monatsschrift für Geburtshülfe und Gynäkologie*, December, 1900.

George R. Southwick, M.D.

RAW MEAT IN TUBERCULOSIS.—Fürster, at the International Medical Congress, gave the following method of administering raw meat in the treatment of tuberculosis: Raw beef or mutton is scraped and then passed through a sieve so as to obtain only the soft meat. This is then rolled into pieces about the size of a strawberry or hazel-nut, and coated with jelly or sugar, according to the tastes of the patient. They are to be swallowed whole, without being masticated, and from 100–300 g. of raw meat can thus be taken without interfering with the regular diet. The simultaneous use of alcoholic drinks in tablespoonful doses every hour is indispensable to the treatment. The reporter does not think the good results which have followed this method are to be ascribed merely to super-alimentation.—*Wiener Med. Wochenschrift*, January 12, 1901.

Wm. H. Bigler, M.D.

SUPPRESSION OF SKIN DISEASES.—Dr. Mattis, of Ravensburg, calls attention to the danger of treating eruptions of infants, such as intertrigo, seborrhœa capitis, and eczema faciei, with astringent salves, e.g., zinc ointment and medicated powders. He had had many cases of young children to treat for obstinate diseases of the eyes, lungs, and particularly the brain, directly traceable to such manipulations. Quite recently he had treated three children from three to five months old for meningitis, occurring about a week after the suppression of an intertrigo, and without any other assignable cause.—*Hom. Monatsblätter*, January, 1901.

Wm. H. Bigler, M.D.

HYPERIDROSIS OF THE AXILLA—ITS TREATMENT WITH THE THERMO-CAUTERY.—Kolipinsky, Washington, D. C., after considerable experience in the treatment of hyperidrosis of the axilla with the various local and constitutional treatments in vogue in the text-books on dermatology without in a single instance noticing the least improvement, turned his attention to the cure of this disease by the use of surgical procedures. After a study of the anatomy of the sweat glands of the axilla and the skin of that region, he devised the following method by which he destroys the secretory ducts of the glands. A thermo-cautery is heated to a bright-red heat; its flat side is then applied from ten to twenty times to the space from which the sweat is seen to ooze. One-half or more of the superficies is turned into burns of the second or third degree. The cauterizing is done in a very few minutes, and the pain is not severe. A dry zinc oxide or bismuth dressing is applied, and the patient may resume his ordinary occupation in a few days.—*N. Y. Medical Journal*, December, 1900.

W. D. Carter, M.D.

INTRA-PELVIC OPERATIONS FOR THE RELIEF OF POSTERIOR UTERINE DISPLACEMENTS.—Chase, Brooklyn, N. Y., after discussing the various operative procedures for the relief of posterior displacements of the uterus, with adhesions, remarks that those operations which have to do with the shortening of the round ligaments seem to be ideal. As between ventro-suspension and ventro-fixation, it would seem that suspension would better meet the exigencies of gestation than fixation, though it would appear that there is greater risk of intestinal strangulation or obstruction in suspension. The danger from both these operations arises from their becoming a barrier to normal and safe gestation. He then relates a recent case wherein a woman in her first pregnancy had been operated for a retro-deviation. It was found, upon completion of gestation, that Nature was unable to accomplish delivery from an anterior fixed position of the uterus, the fundus being close to the anterior abdominal wall. The cervix was fixed high up, posteriorly, by tilting forward of the uterine body, the cervical canal was four or five inches long, and the cervix refused to dilate on the appearance of labor. Cæsarian section was resorted to as the only possible mode of procedure, and twins were removed. The twins survived and the mother succumbed to exhaustion. The operation revealed a dense adhesion about one inch square, holding the uterus close to the abdominal wall. The expectation of the operator that the two to four stitches which united the fundus to the anterior abdominal wall would stretch into a suspensory ligament was not realized, but instead there was an unexpected plastic exudate, which became organized into an adhesion so strong as to hold the uterus immovably forward. (Recently a case was seen in the Hahnemann Hospital clinic where the abdomen was opened, for the removal of the remaining ovary, and a uterus was found firmly fixed to the anterior abdominal wall by adhesions, as described above.)

His observations have led him to the following conclusions:

(a) Posterior deviation with fixation from adhesions is usually a serious menace to health and often a barrier to child-bearing; (b) that this condition of affairs can best be treated by laparotomy; (c) that after the adhesions have been severed the cure should be completed by maintaining the uterus in an anterior position: first, by intraperitoneal shortening of the round ligaments; second, if this is insufficient, resort should be had to anterior abdominal suspension or fixation; (d) that experience, while not settling all points associated with this subject, nevertheless has demonstrated that efforts to maintain the uterus in an anterior position either by ventro-suspension or ventro-fixation are, from the uncertainty of the degree and extent of the adhesions, not devoid of danger in cases of conception.—*American Gyn. and Obst. Journal*, January, 1901.

W. D. Carter, M.D.

SEVENTEEN YEARS OF CONGENITAL NOCTURNAL INCONTINENCE OF URINE CURED BY OPERATION.—Noble, Atlanta, Ga., relates the case of an overgrown girl, 17 years of age, who continued the habit of wetting the bed all her life. All medical treatment had failed, and examination revealed no physical defect in the urinary apparatus. It was noted, however, that the hymen was thickened and inflamed; it was angular in shape, and infiltrated until it was three-eighths of an inch at its base, and had very intimate connection with the meatus. A dissection of the hymen from its attachments with the urethra resulted in a cure.—*American Gyn. and Obst. Journal*, February, 1901.

W. D. Carter, M.D.

COPPER IN CHLOROSIS.—Drs. Taussig and Guidiceandrea, of Laterno, Italy, on account of the intolerance of certain cases of chlorosis for iron, substituted for it the acetate of copper in eighteen cases of that disease. Commencing with a dose of five mgms. it was gradually increased to five cgms., twice a day, shortly after meals. Under the influence of this treatment the general condition became better, and the quantity of the hæmoglobin and the number of red corpuscles increased.

Admitting that iron is the first remedy in chlorosis, he suggests that at times a course of iron may be interrupted by giving this other metal, copper, and above all it is worthy of trial in cases where iron is not well borne.—*La Semaine Médicale*, No. 3, 1901. (Copper has been recommended in some homœopathic works on therapeutics as an occasional substitute for iron; the eclectics call Rademacher's tincture of copper indicated as "a blood-maker after hæmorrhages." In some of the lower animals it takes the place of iron in the red corpuscles normally.)

Frank H. Pritchard, M.D.

ERUPTIONS FROM THE INTERNAL USE OF QUININE.—Dr. Kr. Groen reports four cases of cutaneous eruptions from taking quinine internally, in persons of 16, 18, 25, 38 and 42 years respectively. In four of these the eruption appeared as the usual erythema, with more or less abundant desquamation following; in the fifth case there was a more purely papular form, with a mixture of urticarial efflorescences. As is generally the case, the doses were quite moderate: 0.30, 0.30, 0.15, 0.20, 0.12 and 0.12 respectively. As always, the itching and inflammation were very intense. In one of these cases there was an insignificant elevation of temperature. In two others idiosyncrasy to the drug had been noticed before. One or two of the patients complained of peculiar sensations of tension about the neck, chest and thighs. Twice there was noticed a symptom which had not been described as yet, a spot greatly resembling pityriasis rosacea.—*Norsk Magazin for Lægevidenskaben*, No. 12, 1900.—(I have observed urticarial and even giant urticarial eruptions about the face and neck, in a young girl, to follow the internal use of quinine.)

Frank H. Pritchard, M.D.

A CASE OF POISONING BY FORMALIN.—Dr. L. Zorn observed a man of 44 years who by accident drank about an ounce of a 30-40 per cent. solution of formalin, and, noticing what he had done, at once swallowed some milk and vomited. Transferred to the hospital, his stomach was washed out. He was quite dyspnœic, giddy, anxious, with a burning in his mouth and stomach, and a tendency to vomit. He was wholly conscious, but with a cool skin and cyanotic lips and extremities. For twenty-four hours he passed no urine and his bladder was found empty. The next day, however, he voided a little over three ounces of urine which contained albumin, and both hyaline and granular casts and leucocytes. In the first few days following he had several loose passages. These symptoms, which at the first seemed quite threatening, quickly assumed a milder aspect; the quantity of urine increased, the albumin disappeared, and no casts could be detected. Six days after entering he was discharged as cured. The treatment was limited to washing out the stomach, diet, warm baths and a mineral water—Wildunger water.—*Hospital-tidende*, No. 2, 1901.

Frank H. Pritchard, M.D.

THE BICARBONATE OF POTASH IN THE TREATMENT OF THE GRIPPE.—Dr. S. Harnsberger, in the management of the nervous prostration which is so prone to follow the gripe and which is so liable to last for months, has come to use the bicarbonate of potash in a dose of twenty-five grains in a cup of milk. This is to be repeated every four hours during the day. For the first two days nothing but milk is to be taken, and if it disagrees the remedy may be given in a glass of cold water, taking care to keep the patient on a liquid diet. If at the same time the bowels be constipated he administers either calomel or podophyllin. This treatment, which is especially indicated in old persons and those with weak hearts, will bring about a notable amelioration in thirty-six to forty-eight hours, and convalescence will rapidly go on to recovery.—*Semaine Medicale*, No. 3, 1901.

Frank H. Pritchard, M.D.

TWO CASES OF URÆMIC HEMIPLEGIA, WITH NECROPSY.—Dr. L. Brodier reports two cases of uræmic hemiplegia in patients with chronic nephritis, where diagnosis was not made in either, for in one the disease was of so long duration, twenty-eight months, and there was not a characteristic changeableness of the motor phenomena. In the other, there was an associated mitral stenosis which led to an embolic process in the brain being diagnosed. In neither did a necropsy reveal anything in the brain. Several writers have studied this subject. Such a hemiplegia is usually flaccid during its entire course; there is a certain degree of variability of the motor phenomena. The hemiplegia is of short duration, but may easily recur after an apparent restoration to health. Facial paralysis and aphasia are often associated.

Before the hemiplegia appears there is a premonitory period when the patient complains of oppression, headache, vertigo and disturbances of vision. From his cases and a study of the literature, he warns against being too ready to regard cases of hemiplegia appearing during the course of a chronic nephritis as of apoplectic origin, for they may be of uræmic origin. Therefore, one should be on one's guard against the signs of uræmia. A diagnosis will be difficult, for a heart disease so often is added to a nephritis which may lead to emboli (and the high tension in the arteries may, and most often does, bring about apoplexy).

Such an uræmic hemiplegia is exceptionally long lasting, while there are no trophic nor vasomotor disturbances; the reflexes are not increased. The cause of the paralysis is attributed to local œdema, arterio-sclerosis, spasm of various vessels, etc., yet probably it is of autotoxic origin.—*Hospitalstidende* No. 8, 1901.

Frank H. Pritchard, M.D.

TRAUMATIC DIABETIC COMA.—Dr. Spitzer reports a case which demonstrates that a serious injury may be the cause of the sudden appearance of an acidosis and coma. A man of forty-six, who for several years had suffered from diabetes of a moderate degree, with a generally satisfactory condition, one day slipped on the floor of his bath-room, fell, and broke his clavicle. He immediately became greatly confused mentally, very restless, and felt very ill. The quantity of urine increased, and the quantity of sugar rose from 0.9 to 5 per cent., while the urine was intensely acid. As his whole condition led one to fear diabetic coma, stimulants and great doses of the bicarbonate of soda, 70 gms. daily, partly by the mouth and partly by the rectum, were ad-

ministered. At first a seeming improvement was thought to be noted, but it was soon followed by an aggravation, with deep coma and death.—*Hospital-Standard*, No. 6, 1901. (What a surprise such an event would be to one after an apparently simple fracture.)

Frank H. Pritchard, M.D.

RELIEF OF PAIN BY SUPRARENAL EXTRACT.—Peters (*Lancet*) reports four cases under the above title, and makes a plea for the substitution of this extract for the usual morphia treatment given hopeless cases. The extract is prepared by powdering two tabloids, representing ten grains of fresh gland, and placing them in a test-tube containing one hundred minims of boiled water. The tube is then stood in boiling water for from ten to fifteen minutes, when the contents are filtered—the opalescent filtrate representing 10 per cent. watery extract, having a specific gravity of 1032, and containing 2 per cent. of sodium chloride. If desired, cocaine hydrochlorate can be added to the cooled filtrate. While the extract can be kept for several days by the addition of a little camphor, it is best to prepare fresh sterile solutions.

In the first case, an ulcerating, recurrent scirrhus of the breast, 10 per cent. suprarenal lotion was painted on night and morning, insuring an entire night's sleep, and at the end of three months it was apparently as effective as when it was first used. In case two, a stricture of the œsophagus, the patient slowly sipped a teaspoonful of the 10 per cent. suprarenal extract before going to bed, which induced a comfortable night's rest. In the third case, the pain of laryngeal tuberculosis was remarkably relieved by spraying the 10 per cent. lotion; while, in a fourth, the application of a pledget of wool, soaked in the same lotion and renewed every two to six hours, relieved the pain of a periodontitis after applications of cocaine, iodine, carbolic acid and chloroform had partially or completely failed.

W. B. Van Lennep, M.D.

DISARTICULATION THROUGH THE HIP-JOINT WITH A POSTERIOR FLAP.—Da Costa (*American Journal of the Medical Sciences*) reports a case of fungating sarcoma on the front of the upper portion of the right thigh, with glandular infection in the groin. There being no available skin anteriorly, a long, rectangular, posterior flap was taken from the thigh, and, after disarticulation from in front, was attached to the line of incision starting below the anterior superior spine of the ilium, running along Poupart's ligament to its middle and then to the inner side of the thigh some three inches below the crotch. During the operation hæmostasis was accomplished by McBurney's method of opening the abdomen and compressing the common iliac artery and vein against the psoas muscle. The femoral artery and vein were exposed and tied close to Poupart's ligament. Saline infusion was necessary. The tumor proved to be a small-celled sarcoma infiltrating the muscles but not involving the bone. A quick recurrence took place within the pelvis.

W. B. Van Lennep, M.D.

AMPUTATION AT HIP-JOINT AND REMOVAL OF PORTION OF PELVIS FOR SARCOMA.—Freeman (*Annals of Surgery*) reports a case of periosteal osteosarcoma of the upper extremity of the femur which had assumed enormous proportions in seven months. The growth began just below the fold of the groin, and formed a large tumor occupying the upper half of the right thigh and extending into the pelvis, where masses could be felt above Poupart's ligament. The skin was involved on the thigh and abdomen, and as far inward as the labium majus. A skin flap was raised from the posterior sur-

face of the thigh and gluteal region, and an incision carried from the spine of the pubes, parallel to and well above Poupart's ligament, to above the iliac crest. The peritoneum was turned up, exposing the pelvis, and after ligating first the external and then the common iliae, the growths and infected glands were removed, together with all the soft tissues. Disarticulation was done from in front, and the muscles severed at their pelvic insertions. A considerable portion of the bony pelvis was then sawn off, including the iliac wing and the acetabulum. The loss of blood was slight, and shock readily overcome by stimulation and saline injections under the breast. Wound union and recovery were uneventful, and sixteen months after operation the patient was reported as being free from recurrence.

W. B. Van Lennep, M.D.

RESECTION OF THE FAT ABDOMINAL WALL IN EXTREME OBESITY.—Peters (*Annals of Surgery*) reports a case of Kelly's in which, after removal of the hypertrophied breasts, the abdomen rapidly accumulated fat until it hung down in enormous folds, particularly in front. A transverse incision was made about five inches above the umbilicus from the points of contact with the table on either side. The incision was thirty-three inches long, and went to the muscle. A flap of skin and fat about two inches thick was dissected down for an appropriate distance, when a second incision was carried between the above named points, giving the excised area a double-wing shape, with the umbilicus at the centre. The result after closure was a smooth abdomen without any hanging folds. Wound union was successful, and the patient was kept on her back for over a month, at the end of which time she had lost nearly sixty pounds, the abdominal flap removed weighing between fifteen and twenty.

W. B. Van Lennep, M.D.

SURGERY OF THE PANCREAS.—Dr. Andrea Cegyherelli, of Parma, reviewed the surgery of the pancreas before the International Congress of Medicine, meeting at Paris during the summer of 1900. After reviewing the symptoms, the general loss of flesh, the presence of fat in the excretions, sugar in the urine, bronze taint of the skin, icterus and pain, he speaks of the difficulty of extirpation of the pancreas on account of its anatomical position, its intimate association with the other abdominal viscera, the richness of its blood and nerve supply, and its importance in the secretion of a digestive fluid. If surgery of the pancreas has not advanced with surgery of the other viscera, it is because of the difficulty in diagnosing diseases of the pancreas sufficiently early to attack them at their commencement. Be that as it may, the fact is now known that surgical intervention is more frequently called for upon the extremity than upon the head of the gland. It has been proven by experiments on animals that extirpation of the pancreas is possible and compatible with life. But, clinically, it is not the same, in spite of the existence of these positive facts. The morbid processes which call for extirpation are not usually limited to the pancreas alone. It is more often a question of malignant tumors, associated with infiltration of the neighboring parts or adenomata difficult to diagnose. Extirpation is not rational if the process is tuberculous or syphilitic. Partial extirpation must be executed in such a way as to leave one of the two canals; at least the duct of Santorini should be preserved.

The tumors most frequently found in the pancreas are cysts, which may contain blood, consecutive to traumatism or rupture of a bloodvessel, or cysts by retention or hydatids. In such, intervention is justified and useful; but the

extirpation of the organ is not necessary, the extirpation of the cystic sac being sufficient, if it is possible, or its excision. In extirpation of the sac, the point to be guarded is the opening of the canal of Wirsung and the possible escape of the pancreatic juice into the abdominal cavity. In the incision of the sac it is prudent, if possible, to suture the walls of the cyst to the abdominal walls; if not, to suture with great care, to be sure that the cavity of the cyst is completely closed.

In pancreatic calculus surgical intervention is useful. An affection recently and carefully studied is necrosis of the pancreas for the removal of the necrosed fragments. In suppurative and gangrenous pancreatitis the rule is to abstain during the acute period; but later, if the presence of an abscess or gangrene of the pancreas can be made out, it is urgent to intervene, and a choice of three methods can be made: lumbar, extra-peritoneal, transplural or median subumbilical. One must avoid suppuration, but sometimes it is necessary to eliminate a portion of the infiltrated or necrosed pancreas. The chronic pancreatitis can complicate the common bile duct or the pylorus; in this case surgical intervention may be useful, not so much for the pancreas as for the stomach and liver, to check the effects of compression.

In hernia of the pancreas following injury, the reduction and even fixation may be necessary, the thoracic method being preferable if the hernia is diaphragmatic. In contusions or injury to the pancreas, surgical intervention may be necessary, particularly if there is hæmorrhage. The surgeon should either suture or ligate the bleeding vessel, removing at the same time all clots from the abdominal cavity. Movable pancreas has been observed; experimental pathology in such cases authorizes the fixation of the gland. In invagination of the pancreas, the surgeon can and must interfere if complications arise, and if the process of elimination is not regularly made. When, following a diseased process in the neighboring parts, the opening of the pancreatic duct into the duodenum becomes closed, a new path must be created for the pancreatic juice, or, if this is impossible, a pancreatic fistula. In hæmorrhages of the pancreas resulting from disease, most frequently gangrene, the surgeon must act as in traumatic hæmorrhage. In stricture of the pancreas it may be necessary to cut the stricture, or to operate to prevent injury to the stomach or intestines. The points of the suture directed across the parenchyma of the organ give rise to no trouble or alteration, and are tolerated the same as in the kidney, spleen or liver.

To-day there is no further doubt of the regeneration of the pancreas. After the complete extirpation of the pancreas the multiplication of the glands of Galeati, and, above all, the karyokinetic growth of the epithelium, would lead one to believe, after the experiences of Martinotti, that these glands will be able to sufficiently replace the extirpated viscera. The escape of the pancreatic juice into the abdominal cavity does not always cause peritonitis, because the absorption is rapid. One would suppose that the pancreatic juice, like the bile, is inoffensive if it is healthy, and harmful only if it is altered. In extirpation of the pancreas it is necessary to be careful to make the ligatures before the incision, to avoid hæmorrhages and the escape of the pancreatic juice. The thermo- and galvano-cautery must not be used; they do not sufficiently guarantee, because of the failure to produce the eschar, and, again, because the induration may produce dangerous effects upon the neighboring parts.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

TEREBINTHINA : ITS EFFECT IN A CASE OF TYPHOID FEVER.—Royal, of Des Moines, Iowa, had a rather unique case of typhoid fever recently, which he relates, with comments, in the *Medical Century*, and in which the action of turpentine was, we think, worthy of notice. The patient, a young German, had been ill for three weeks with the disease, and had been given Bryonia from the first until the thirteenth day, when pain in chest, rapid respiration and bloody sputum decided the doctor to change to Phosphorus. Under the latter remedy improvement went on until, by the nineteenth day, the temperature and pulse were normal; but there remained a tenderness of the abdomen. On the morning of the twenty-first day the patient was found in an apparently critical condition, his temperature being 105°, his pulse 154, his face pale, abdomen much distended, and lower extremities covered with a cold sweat. For these symptoms, as well as the small, rapid, compressible pulse, his physician gave him *Terebinthina* 6x, two drops in water every half hour, fearing that he had to deal with a case of intestinal perforation. In addition, lard and turpentine was applied to the abdomen, and later in the day ten drops of the oil of turpentine in three pints of water were injected into the bowel. The patient passed much flatus under this treatment, and the *Terebinth.* 6x being continued, he was again convalescent on the twenty-eighth day. Now, it is hardly likely that perforation occurred in this case, yet the symptoms described were certainly of very serious import, and suggestive of a complication of some sort. *Terebinthina* is one of our best remedies in the third or fourth week of severe and tedious typhoids, and it suits a clinical picture that is not as well covered by any other drug. The tongue is *dry, red, clean and glossy*. It may seem hard and stiff, and cannot be kept moist even by frequent washing. The abdominal tension increases and *the tympanitic distension is great*. There is pain in the abdomen and tenderness to pressure. The temperature keeps high.

The patient mutters and has *subsultus tendinum*. He is rather stupid. *His body is hot, but his limbs are cold and clammy*, even when hot-water bags are used. *His pulse is small and weak*. If he is constipated, you have much trouble in moving bowels by the enemata, and if he has diarrhœa, *his stools contain blood*. His urine contains albumin and, of course, casts. The kind of a case that keeps you awake nights thinking about it, yet one that you somehow feel will recover—if perforation or hæmorrhage do not occur. Well, it is in such conditions as this (which we have described from memory of several such) that one finds a helpmate in *Terebinthina*.

O. S. Haines, M.D.

URTICA URENS.—At the Forty-eighth Annual Meeting of the Homœopathic Medical Society of the State of New York, the Bureau of Materia Medica held “An Experience Meeting,” at which some very interesting remarks were made by the various members. Dr. W. H. Proctor, of Binghams-ton, gave the following interesting personal experience: “In the spring of 1899 I was afflicted with retention of uric acid in the system, which produced for its first symptom an agonizing pain in the right deltoid muscle. Morphine hypodermatically was used. Then followed, for some three weeks, scanty, pale urine; sour sweat, sleeplessness, restlessness, loss of appetite, and constant pain in the deltoid, with great soreness and lameness in the muscle. An intense sensation of general sickness and weakness, with continued fever. Neither internal medication nor external application was of use. Finally, at the end of the third week, a new symptom appeared, which brought a new remedy to mind; that symptom was ‘an intense burning sensation in the skin after sleeping, so intense that I was afraid to sleep.’ After three doses of *Urtica urens* I dropped into a refreshing sleep of three hours, and awakened free from all symptoms of the irritation. All the remaining symptoms passed rapidly away.”

Dr. Burnett, of London, says that *Urtica* is the most potent remedy against uric acid that we have. Dr. Proctor mentions the case of a gentleman who came to him complaining of constant pain, soreness, and lameness of the deltoid, for which he had taken remedies for several months, without obtaining relief. Ten drops of *Urtica urens* night and morning cured him. The doctor thinks that this pain was due to a deposit of the urates in the muscles and tendons, and that this remedy has the power of carrying this deposit away. It strikes us, after reading this interesting experience, that there is one other moral to the story. It is the “peculiar, uncommon and unusual features of every symptomatic totality” that are the most important. These are the ones that direct our attention towards the proper remedy. We doubt if Dr. Proctor would have found his similimum had not one of these unusual and peculiar symptoms arisen. Therefore, why not say “thanks” to Hahnemann; for he was the first man who ever knew enough to tell the medical profession that it is the peculiar and uncommon and unusual and characteristic features of every case that constitute the *indispensable features* of the symptomatic totality. These are the ones upon which the homœopath must ever base his successful prescriptions, in cases amenable to drug therapy. Dr. Proctor’s remarks have increased our interest in the pathogenesis of the *Urtica urens*.

O. S. Haines, M.D.

CALCAREA CARBONICA 200 IN RENAL COLIC.—Many years ago, as most fairy tales begin, we wrote an article upon this very subject. It came about in this way: A series of cases of renal colic coming under our observation, some half dozen in number, had all yielded nicely and promptly to *Calcarea* in a high potency. In none of these cases had it been necessary to resort to the hypodermatic administration of morphia. The therapeutic outlook became suddenly quite encouraging. The paper was born and published. Well! The things that happened to us, in the way of intractable renal colics, during the succeeding year or two, were enough to make even a sanguine man pessimistic. Indeed, at one time, we feared that it would be necessary to purchase a “rabbit’s foot” to turn our luck. And so, while we enjoyed

reading Dr. Walter Sands Mills's article in the *Medical Century* for March, and while we admired its systematic completeness, yet we could not help wondering whether the author hadn't better "touch wood," just for luck, you know.

Dr. Mills' comparison of the symptoms found under *Calcarea* in Allen's Encyclopædia with the symptoms of an attack of renal colic would convince any homœopath that the drug bears a symptomatic relationship to the affection under consideration. The clinical cases, five in number, which he offers in proof, are well worth reading. He says: "I have a profound faith in the indicated homœopathic remedy." So have we, but our pride was wounded too deeply, after we wrote *our* article, for us to be willing to include renal colic in our profound faith just yet. The author further says that *Calcarea* is a drug that impairs nutrition and causes a deposit of the earthy salts. Now, as renal calculi are due to faulty assimilation and consequent deposition of salts in the kidneys, *Calcarea* ought to be homœopathic to renal calculi. It may stop the tendency to the formation of these calculi. Papers of this kind are valuable; they stimulate us to renewed labor in the right direction. Let us remember *Calcarea* 200 in our next case of renal colic.

O. S. Haines, M.D.

THE TREATMENT OF INSOMNIA.—Halbert, of Chicago, in speaking of the remedies which may be used internally for the purpose of inducing sleep, says that we should seek the aid of a remedy only to correct the cause which creates the insomnia, and that remedies should not be used that bring about sleep simply by their drug action. He thinks the only excuse for an opiate is the existence of pain. The author refers to a number of remedies which, we think, are not commonly used, and which we present, with brief extracts from his indications for their use.

Camphor has a well-defined set of symptoms; thus there is extreme restlessness, with mental anxiety, associated with which we invariably find a vertigo and a feeling of brain constriction. The patient is erratic and unreasonable, is afraid to be alone, and is in a constant state of agitation. He has cold extremities, and cannot sleep in consequence of this. Cold air aggravates the camphor patient, so it naturally follows that the remedy will be of greater value during the cold season.

Cannabis Indica.—Look for a symptomatology with prominent hallucinations. Sleep is of a fitful character. It does not call for an absolute insomnia; it refers more to the *irregular* sleep. Constant waking under the impression of peculiar dreams. Sexual perversions are common. In delirium tremens and in acute mania it is frequently useful. Do not use it lower than the third potency. (These suggestions as to dose are commendable; we homœopaths often spoil the effects of a good prescription by giving tinctures when we should prescribe a dilution of the same.)

Digitalis.—*Cardiac weakness* is so frequently the fundamental disturbance in these conditions that we should be on the lookout for its indications. When the heart is weak, there is a cerebral excitation, and this, with the general vaso-motor disturbance attendant upon anæmia and debilitating diseases, should direct our attention to this remedy. Mental depression is a pronounced symptom.

Asafetida.—Irritation of the nervous system from some *reflex* cause is one indication for this remedy. Hence it is often useful in hysteria as a result of uterine perversions. The patient is ill humored, irritable and apprehensive, and this keeps the mind awake and active. Gastric eructations, feeling of the "globus hystericus," bowel distention, griping pains and uterine disturbances are factors in connection with insomnia. This remedy is to be used in potency and not in crude doses.

Hyoscyamus.—In cases of extreme neurasthenia, when the mind seems to refuse to quiet down, he uses ten drops of the tincture at bedtime, and repeats it if necessary. The 3x potency of hydrobromate of hyoscyamine will often overcome obstinate insomnia. There is in the Hyos. case no depression, but always animation and a restlessness of body and mind. No sign of rest for any nerve in the body, hence twitchings and involuntary movements occur. Hyoscyamus in potency must be given often and for a considerable time to effectually conquer the disease.

Valerian pertains to a form of restlessness in which *fatigue* is evident. And *pain*, too, is often a factor, so that it may be used in neuralgias. It is useful in its combinations with zinc and ammonia.

Amyl Nitrite.—When there is insufficient cerebral circulation in consequence of aortic obstruction. Headache, with heat and throbbing, and a sense of intense fullness is the characteristic symptoms attending its insomnia. Feeling of constriction in throat and chest, dyspnoea and asthmatic breathing. It is useful in potency.

Coffee.—The patient cannot sleep because he cannot stop thinking. Ideas force themselves upon his mind, and mental activity is at its best. All the senses are extremely acute.

Camphor Monobromide in the first and third potencies has served him well when an organic nerve disease is present. For instance, the insomnia attending locomotor ataxia or epilepsy may be corrected by this remedy. Give the remedy in lower potencies only during the evening; if the higher are used, it may be given for some time.

Phosphoric Acid suits a peculiar class of patients; those who are suffering from the remote effects of a loss of fluids. The general weakness incident to the losses and the nervous debility lead to distressing states of insomnia which will be corrected by this remedy given in low potencies for some little time.—*The Clinique*, February 15, 1901.

O. S. Haines, M.D.

THE URÆMIA OF ELDERLY MEN.—It is a very familiar clinical experience that Dr. Clifford Mitchell depicts in his recent paper upon the above topic, when he describes certain cases of elderly men with enlarged prostates or more or less cystitis and pyuria, who die either comatose or in convulsions from some sort of chronic poisoning which in a general way we call uræmia. While the ultimate cause of death, in a large number of old prostatic cases, is undoubtedly either pyelonephritis terminating in coma, or hydronephrosis with resulting interstitial nephritis and uræmia, still the writer has seen cases in which no evidences of either of these lesions were demonstrable, yet the patients slowly sank and died comatose.

The author advances, in detail, the following hypotheses to account for these obscure cases:

First. The likelihood of the existence of forms of chronic nephritis not yet well recognized, but which are intermediate between chronic interstitial nephritis and senile contracting kidney, in which uræmia is a prominent feature, although cardiac hypertrophy, high-tension pulse, atheroma of arteries and retinitis may not be present. In short, the clinical features being merely a chronic uræmia, together with urine of poor quality and evidences of cystitis.

Second. That the uræmia in such cases is due, either entirely or in part, to actual absorption of urinary salts in the bladder itself, from residual urine there. These old men manifest certain characteristic symptoms for some time before the uræmic coma, so that even the members of their family may observe that "the old man is failing, is not what he used to be," etc. Then "dull headache, bodily and mental lassitude, the face becomes expressionless and indifferent, the patient does not know exactly what he is doing." "Then he sleeps more than usual, rouses when spoken to, but falls again into a stupor." "After awhile he falls again into a stupor from which he cannot be aroused, and finally dies comatose."

The problem of the therapeutic management of such cases seems to be difficult of solution, and about the only hope, says the writer, lies in persistent, though *gentle*, eliminative measures. *Jaborandi*, in some instances, seemed to be of benefit. Two-drop doses of the first decimal dilution every fifteen minutes produced a welcome perspiration, following which the patient awoke from his stupor. The writer has seen a number of drugs used in large and small doses in various cases of this kind, but cannot, he says, report flattering results save in the few instances where the *jaborandi* was beneficial.—*Medical Era*, January, 1901.

O. S. Haines, M.D.

HAVE WE KEPT THE TRUST SACRED?—Dr. N. R. Perkins, of Boston, said recently: "To-day, with large corps of professors and advanced methods of teaching, the opportunities for study are better, but *is there* a corresponding increase of knowledge of the materia medica? A method of generalization has crept into our practice. You, my colleagues, and I indulge in it, and by so doing we are undermining that *foundation* which was laid deep and well by the fathers and given to us as a heritage upon which to build the superstructure, beautiful and perfect in all its lines and proportions, strong in every portion, so that it should be as lasting as the eternal hills. Have we kept that trust sacred? Must future generations wonder where is the house beautiful?" (Homœopaths! Take notice.)

O. S. Haines, M.D.

IRIS VERSICOLOR IN OPHTHALMIC MEGRIM.—Miss J., age 30, large built, nervous, regularly menstruated, and in perfect health, except she suffers from an ophthalmic megrim.

For over eighteen months she complained of visual disturbances, with headaches. The prodromal symptoms were a blur before the eyes, and at times she could only see half of the objects; for instance, half of the face, the right or the left—Vertical hemiopia. To these soon followed a violent hemicrania. Belladonna, Phosphorus, Spigelia and Iris are indicated in ophthalmic megrim, but iris was more particularly so in this case, the patient suffering from an obstinate chronic constipation. She received iris 30th dilution, 6 globules in

200 grammes of water, a tablespoonful four times per day. Four days after, a great amelioration was noticed, and continuing the remedy for a few days longer, and administering two tablespoonfuls per day, patient was cured.—Dr. P. Jousset.—*L'Art Medical*, January, 1901.

John Arshagouni, M.D.

ANOTHER CASE OF MEGRIM CURED BY ANTI-SYPHILITIC TREATMENT.—Dr. Lamy, at the meeting of the Société Médicale des Hôpitaux (14th Dec., 1900), presented a paper on a case, the following symptoms being the essential features: Female, age 26; suffering for six months from violent attacks of megrim localized around the eye, and associated with nausea and vomiting, the attacks becoming closer every time, and finally they were occurring daily, and soon accompanied by ptosis of the painful side. This ptosis lasted as long as the megrim, and was always present in the affected side, at times the right, at others the left. During one of those crises the patient had a dimness, and became unconscious for a few minutes. When revived, the megrim had left her; but she felt it again fifteen days later, and it stayed permanently, but changed its location several times per day. Later, ptosis became constant for a month; still later, both eyes became likewise affected.

On the 29th May last, she appeared with a ptosis of the right side, violent pains in the temporal region of the same side, the right pupil was dilated, and almost insensible to the light. She furthermore complained of great weakness of the memory, hardly able to describe her history; she was constantly nauseating, and her gait was unsteady. The left eye normal. Although no specific history was given, Drs. Lamy, Martin and Lannois put her under the mixed treatment, and the patient was cured. This certainly was not a megrim of ophthalmic variety, but, as Dr. Ballet calls it, periodical pseudo-megrim, symptomatic of an organic lesion.—*L'Art Medical*, January, 1901.

John Arshagouni, M.D.

A NEW VENOM.—Dr. Phisalix read a paper before the Biological Society of Paris at their meeting of 8th December, 1900, upon the cutaneous secretions of *Lulus terrestris*, a myriapod which, when irritated, rolls upon itself and secretes from its glandular orifices a yellow liquid impregnating the skin, and the strong and pungent odor of which lasts several hours.

The venom was obtained by putting the animal in water, where the secretion is dissolved, coloring the water yellow.

Dr. Phisalix having thus obtained 25 c.c. of distilled water impregnated with this venom, studied its physiological action.

Injecting hypodermically into a guinea pig, the venom produces very severe pains, followed by swelling. The next day a small sore at the punctured spot, a more or less extensive œdema, but not followed by general symptoms. Injected into the peritoneum, the venom very promptly produces a subacute peritonitis, characterized by very violent pains, hiccough, efforts of vomiting, breathing stertorous, prostration and chills, at the same time temperature rapidly lowers, and from 9 A.M. to 10 P.M. falling from 39.5° to 29.2° C.

Post-mortem examination revealed general peritonitis, sero-sanguinolent effusion, and over the liver a grayish pseudo-membrane.

Chemical researches made with the greatest care by Drs. Béhol and Phisalix resulted in classifying this venom of *Lulus* with Quinone, as both, besides their chemical similarity, have similar physiological action upon the guinea pig.—*L'Art Medical*, January, 1901.

John Arshagouni, M.D.

THE HAHNEMANNIAN MONTHLY.

MAY, 1901.

THERAPEUTICS OF BRIGHT'S DISEASE.

BY CLIFFORD MITCHELL, M.D., CHICAGO.

Professor of Renal Diseases in the Chicago Homœopathic Medical College.

In the treatment of chronic nephritis the writer finds the following course of action advisable:

1. Find out what the patient is eating, drinking and doing.
2. Examine the urine with reference to twenty-four hours' quantity, ratios of urea to phosphoric acid and uric acid, amount of albumin, and constituents of the sediment.
3. Regulate the diet and mode of life.
4. Prescribe with reference to the symptoms of the patient and the character of the urine.

In the writer's experience too great attention cannot be paid to what the patient is doing. It is, as a rule, useless to expect drugs to overcome the ill-results of an injudicious mode of life. Late hours, dissipations, excessive venery, depression of the nervous system from various causes, mental strain and physical over-exertion combine to nullify the most careful prescribing. The effects of protracted rest in a recumbent posture have been attended with such remarkable results, when faithfully tried, that every effort should be made to keep the patient in bed every spare moment. A simple proof of the efficacy of rest is easily to be had by comparing the amount of albumin in the urine voided on rising in the morning with that voided late in

the day. Mental, physical and digestive fatigue increase the amount of albumin in the urine, and no drug with which the writer is familiar can reduce the quantity when such fatigue is undergone by the patient.

In the matter of diet, the combination of meat with sweets, beer, or champagne is the worst one for the patient. This is particularly true in cases of contracting kidney, as pointed out by the writer in a recent article in the *Medical Era*. In the same article the value of buttermilk in the diet was commended.

In the present paper I intend to give therapeutic agents chief attention. The remedies, which may be called the Renal Group solely from the standpoint of my own clinical experience, are the following: Potassium citrate, jaborandi, iron, apocynum, hydragogin.

In defence of this grouping, I will say that while potassium citrate and jaborandi may more properly be classified under the heading of diaphoretics, nevertheless I regard them as also having diuretic properties. Iron may belong in some other class, but I cannot treat renal diseases without it.

In addition to the above, there are certain agents which may be called adjuvants to the Renal Group. These are the following: Strychnine, Pluto water (concentrated), elaterium, cratægus, aconite, glonoin, the glycero-phosphates, caffèine, [chloralamid], morphine, digitalis.

In the above list chloralamid is bracketed for the reason that I have not as yet used it, but will merely refer to it later on. This paper will, moreover, not treat of remedies known to be useful in diseases of the urinary tract other than nephritis. Some surprise may be occasioned by the fact that turpentine, arsenicum, cantharides, merc. cor., apis and other well-known remedies are not included in either of the above lists. This is because I am usually called to see cases in which these remedies have failed to do the work required. It must not be understood, however, that I leave them out with any intention to disparage their value.

The first agent to be considered is *potassium citrate*. In the writer's hands this drug has been most useful in cases where the feature is scanty urine, tending to diminish still further in quantity, with or without dropsy. The following cases serve to illustrate its action:

CASE I.—Mitral stenosis and chronic renal hyperæmia in male adult; urine only nine ounces in twenty-four hours; contains a trace of albumin and a few yellow casts. Sediment also contains urates. Specific gravity of the urine 1026. Patient œdematous above the knees and has considerable difficulty in breathing.

Potassium citrate in 30-grain doses, four times daily, and arsenicum, removed the dropsy and increased the urine so that patient could attend to his business.

CASE II.—Old gentleman with retention of urine and threatening suppression from acute intercurrent attack of chronic interstitial nephritis. Albumin one-third of one per cent. bulk and innumerable dark granular casts, a few fatty and a few waxy casts. Urine somewhat concentrated, hyperacid, deposits uric acid crystals. Patient weak and inclined to be drowsy, but shows no other symptoms. Potassium citrate increased the quantity of urine promptly; the patient recovered from the acute attack, and now (two years later) is apparently well. Condition of urine at present time not known.

CASE III.—Child of 2 years with acute nephritis. (Edematous, pallid, and becoming drowsy. Urine about twelve ounces in twenty-four hours, and loaded with albumin. Potassium citrate in fifteen grain doses increased the urine, diminished the albumin and relieved the drowsiness. The diaphoretic action in this case was noticed as helpful and not unpleasantly severe.

Jaborandi has a peculiar value in the treatment of nephritis, especially since Professor Wieland's interesting discovery of the elimination of urea effected by the saliva. From many standpoints *jaborandi* is one of the most remarkable drugs in our materia medica, as can be seen from the numerous experiments made with it by those who study physiological chemistry. Given a patient who is slowly sinking into uræmic slumber, especially an old man, or a patient in uræmic convulsions, and *jaborandi* will bring him back to life if anything will do it.

In an interesting conversation which I had with the late Dr. Purdy in regard to pilocarpine in renal therapeutics, he expressed the opinion that it was a dangerous drug in chronic nephritis, but a useful one in acute nephritis. This is, of course, true as a

general proposition with reference to hypodermic use of pilocarpine in cases where respiration is for any cause impeded. But in cases of chronic nephritis, where dyspnœa is not a feature, I have used jaborandi, followed by digitalis, with good results. The dose and method of administration have already been described in my "Renal Therapeutics."

Iron certainly appears to be useful in the treatment of chronic nephritis. In my experience it has been more serviceable in the case of women than of men, and to such degree that I seldom fail to advise use of it in some form or other for female patients with Bright's disease. The forms most frequently used have been Boudreaux's syrup and pills of the protochloride, Basham's mixture (ammonio-acetate), and the preparation known as hæmoglobin, with or without arsenic.

Anæmia, dropsy, highly albuminous urine containing casts, and more or less debility in obstinate cases where the urine is not noticeably scanty nor cardiac symptoms marked, have been the features of cases which iron has relieved or cured. Arsenicum, mere. cor. and apis have usually failed in these cases. The patient may declare that but for the condition of the urine she would not know she was ill. Of interest is a recent case in which the urine contained numerous highly fatty casts and an enormous number of fatty masses, in addition to a large amount of albumin. Hæmoglobin and Basham's mixture, alternately, have reduced the albumin to 10 per cent. bulk, and cleared the sediment of fatty casts and masses after a few months' treatment.

In one case, somewhat similar to the above, something had to be done to relieve the dropsy, which became excessive. About that time my attention was called to the efficacy of a preparation known as *hydragogin*, which was tried after failure of other means. After administration of this agent for a day or two the patient began to void an enormous quantity of urine, the dropsy left her, and she went back to work, to the astonishment of herself and friends. I do not regard her, however, as cured, but merely mention the case as one of clinical interest from the standpoint of reduction of obstinate and increasing dropsy. I now regard her as in condition calling for the continuous administration of iron.

A difficult problem is sometimes encountered in the case of young women in delicate health who have slight albuminuria,

which, however, is persistent and can hardly be deemed "functional." It would appear that anæmia is responsible for the albuminuria. Nevertheless, owing to the possible danger of puerperal nephritis, we hesitate to advise such patients to marry. When, however, they marry in spite of advice to the contrary, the need for renal relief becomes more urgent. In one such case persistent albuminuria, covering a period of two years or more, with occasionally cylindruria, finally yielded to continuous administration of the preparation known as peptomangan. It must be said, however, that the patient moved away from the lake region into the interior of Illinois, and the change may have had much to do with the reduction of the quantity of albumin from several per cent. bulk to the merest trace.

Apocynum still holds its own in the writer's hands as a diuretic in certain cases. A peculiarity in reference to this drug is its nauseating effect on some patients. I have known those who could not take seven drops of the tincture without nausea. Others may take twenty or thirty drops without disagreeable effects. In half a dozen cases the urine has been increased in quantity and dropsy with dyspnœa relieved by this agent. I am not altogether certain in my mind as to the indications for use of it, but, as a rule, it has been most beneficial in the case of male patients with various cardiac symptoms. In the case of a female child with acute nephritis, pallor and dropsy, the urine gradually decreased in spite of *apocynum*, but when I alternated potassium citrate with it, in fifteen-grain doses four times daily, the urine began to increase after twenty-four hours and albumin diminished rapidly. The use of *apocynum* in connection with potassium citrate is something which may possibly be studied with profit.

In cases in which it seems more likely that the condition is cardiac rather than renal, and in which we are in doubt as to the exact diagnosis, owing to the severity of the symptoms (weakness, dyspnœa, dropsy) not being satisfactorily explained by the constitution of the urine, I have given *apocynum*, *crategus* and *strychnine* alternately, and in one or two cases rallied the patient and prolonged life.

In the last stage of contracting kidney with dilatation of the heart, the patient is sometimes unable to sleep. In such cases a hypodermic of *morphine* at night is often administered.

The only comment the writer has to make is by way of emphasis in following the warning given in recent works on Practice not to repeat the dose in increased amount, as is sometimes done, with fatal results in cases of interstitial nephritis.

Patients with chronic interstitial nephritis sometimes complain of throbbing in the head, ringing in the ears and attacks of dizziness, the latter sufficiently severe to interfere with attention to business. In such cases I prohibit meat entirely for the time being, and give *aconite* 1x and *glonoin* 2x, at the same time advising the use of a laxative water as Célestins Vichy. My attention was called to *aconite*, in connection with these cases, from the relief it invariably gives to a certain patient year after year, who is subject to these symptoms at times. I suggest further study of this drug in cases of arterial tension and contracting kidney.

In patients with contracting kidney and albuminuric retinitis, I have known *sodium glycero-phosphate* (phospho-glycerate) to be apparently of value for the time being. I prescribe it in cases in which the ratio of urea to phosphoric acid is high, that is above 12 to 1, on the theory that the organism for some reason needs phosphorus. One patient certainly improved more under five-grain doses of this agent than on anything else, but it is, of course, difficult to say positively whether the drug had anything to do with it or not. It is, nevertheless, demonstrated clinically that in chronic interstitial nephritis we frequently find a high ratio of urea to phosphoric acid, and I have shown that in cases in which the total amount of phosphoric acid is less than 1 gramme (15 grains) per twenty-four hours, the mortality is higher, and the prognosis as to time worse than in cases where the amount is over 20 grains per diem.

(In connection with albuminuric retinitis, I repeat here what I have said in the *Era*, that the patient who broke all records for length of time of survival after onset of retinitis subsisted for years almost entirely on buttermilk.)

Those who have contracting kidney may be afflicted with chronic headache or occasional attacks of agonizing cephalalgia. In such cases meat should be prohibited altogether during the headache. Glonoin is often disappointing in the treatment of headache during renal disease. The chronic headache may sometimes be palliated by two-grain doses of the pure alkaloid *caffèine*. This I have learned from a patient who has had

chronic headache for years, and who has tried all known means for relief. Two grains of caffeine will almost instantly relieve this headache for the time being. He has averaged about seven grains of caffeine a day for as many years, apparently without ill effect. He finds that occasionally caffeine fails to relieve him; on such days he takes twenty grains of salicylate of sodium, and this will then relieve him.

In an interesting and cleverly written paper on *chloralamid*, by Dr. Clevenger, I notice that claims are made in regard to the efficacy of this drug in relieving the headache of nephritis. Anything other than morphine which will relieve the agonizing attacks of cephalalgia is certainly worthy of trial. I know of few things more distressing or more difficult to palliate than these same headaches. At the same time, if chloralamid is a cardiac stimulant, its use in cases of cardiac hypertrophy may not be devoid of danger.

It frequently happens that in the course of chronic nephritis the patient is relieved of dyspnœa and dropsy by *profuse watery stools* in connection with administration of *strychnine*. This may be observed in the last stage of chronic interstitial nephritis when dilatation of the heart sets in. In several cases I have prolonged life by use of *concentrated Pluto water*, which is well borne by robust patients. Fifteen or twenty watery stools in the course of a day will often relieve the terrible distress in breathing. (Pluto water has been of service also in reducing dropsy in one or two cases reported to the writer by Chicago physicians, the particulars of which I have not at hand, but which are said to be cured. They were probably not in the last stage of contracting kidney.) Those who are weakened by salts sometimes receive benefit from elaterium instead.

What is needed by way of addition to our therapeutic knowledge is more light on the treatment of lardaceous disease of the kidneys. The writer sees but few cases of this character, and has had little opportunity to study the effect of therapeutic agents upon them. In the books we find *the iodides*, especially the iodide of iron, recommended. I have tried the iodide of arsenic in this affection without any results that I could see. Anyone who will contribute to our stock of remedies for the medical treatment of this grave disorder will do us a real service.

COMMON SENSE IN MEDICINE.

BY EDWARD R. SNADER, M.D., PHILADELPHIA, PA.

(An Address delivered before the Homœopathic Medical Society of the State of Maryland.)

IN some inscrutable way there prevails in the medical, as well as lay mind, the idea that medicine is of mysterious, nay, even Divine origin. It is impossible to analyze the source of this tacitly-received impression; but the fact remains patent that a certain inexplicable reverence attaches itself to the dominant views and sentiments prevailing in medical minds towards ideas advanced and promulgated by men who have been great in medicine. Indeed, when the dicta of the leading lights of medicine, particularly the ancient ones, are brought under suspicion, one feels almost as if he were committing sacrilege. There prevails to-day no more erroneous view than this cloudy and nebulous conception. True progress will only be made when the idea that we are treading upon sacred ground when we question the truth and wisdom of the aphoristic dicta of leading lights in medicine shall be utterly abandoned. Let us turn on the electric flash-light of common sense, and accept the very patent fact that *medicine and all its procedures for the cure and amelioration of disease are pre-eminently and solely of human origin*. This conception vastly increases our dignity as doctors, and still more vastly increases our responsibility. Let us forego the dignity, and bare our backs to the burden of the enormous responsibility. If medicine and its methods are of human origin, you and I have as much right to an opinion as the most favored son of Æsculapius. But we must accept this responsibility with a full knowledge of its awful significance. Again, if medicine is of human origin, we can actually save life, by virtue of our judgment and the brains our heavenly Father has dowered us with. Yes, we can actually save life, and, woe is me, sacrifice it, to worn-out theories and misconceptions of the power of the therapeutic means at our command. We have heard much of the healing power of nature. Yes, but we must guide that healing power in the proper direction, and this we

cannot do without the proper exercise of supreme common sense. There never existed a medical Mount Sinai from which has been thundered forth a series of immutable commands that medical men must follow. Medicine has been born of human thought, human endeavor, human sacrifice, human bravery, and we as doctors are members of the noblest profession on earth, for to our keeping has been committed the temples in which dwell human souls. We are high priests at the altar of the holy of holies, the human body, wherein God has housed his own image. But this high priest function is ordered by no sacred ritual; we are free to act with the brains we were born with. Let each one of us realize, then, that he must, in the interest of his great calling, be a ruthless iconoclast of all preconceived opinions if they do not correspond to the dictates of common sense. We must throw overboard the most cherished beliefs if they are not endorsed by supreme common sense. We must entertain no belief for the sake of entertaining it, or because we love the belief, or because it was taught us at our medical mother's knee.

If, then, medicine is not of Divine origin, and is made by humans, it must be subject to all the possible errors to which things human are liable. Medicine as a science has made errors. Her path of progress is strewn with the wrecks of exploded theories. This being true, the utmost caution in receiving anything new is enjoined upon us by common sense. If all medical knowledge is human, we can, by virtue of the right of free thought, place our lance in a medical foe in a knightly battle for the truth. But we must fight for truth as we understand it, and not merely for the purpose of defending a tenet because it has been held by us so long that it seems an integral part of us. It is common sense to know that all truth is only relative. Truths so cross and intercross in the various problems that face medicine that what is truth to-day may not be truth to-morrow. Only the great fundamentals hold their own, and fundamentals may be modified by an equally great fundamental. We can, then, without shame or fear of reproach, question all theories, all dicta, in medicine, for we are responsible to no worthy, ancient or modern, for the care of the sick placed in our charge, but only to our own consciences and to God. It is the supremest common sense, therefore, not to adhere to

ideas the usefulness of which time has demonstrated to have passed away. It is a crime to fail to receive the effulgent light of new discoveries. The hoary and fossiliferous theories that dominated medicine in its adolescent period must give way to the new-born ideas of the vigorous-blooded heroes of the shadowy end of the nineteenth century.

Have you ever, when bowing the knee in the secrecy of your thought-chamber to common sense, asked yourselves why you resorted to certain therapeutic procedures? asked yourselves why you gave certain medicines to a certain case? Have you not, in an apparently common-sense way, begged the question, and said, "*Why, to cure, of course*"? But have you gone no deeper than that? Have you asked yourselves how and by what means a cure can be wrought? Have you asked yourselves upon what, *essentially*, must all drug action depend? If not, you are poorly panoplied to battle with disease. Has it not occurred to you that drugs, that all therapeutic actions, must depend upon some central principle? Perhaps in your cogitations you have temporarily lost sight of the fact of the existence of the ultimate anatomical element, the cell, the foundational element.

All therapeutic measures of any description whatsoever, called by whatever name you please, are dependent for their action, for good or ill, *upon their power to influence the function of the cell*. Analysis will show this proposition to be the quintessence of common sense. If this self-evident proposition be accepted, it follows that, in the very nature of things, there are many ways in which the function of cells can be altered. No one here, I am sure, will tell me that I cannot modify the cells composing the end of my finger in a hundred ways—by heat, by light, by cold, by water, by drugs, by electricity, by the knife, by pressure, by relaxation, by muscular movement. If this be true of the cells of the end of my finger, it is equally true of every individual cell and of every aggregation of cells in my body. Is it common sense for us, as homœopaths, to wrap ourselves up in the mantle of Pharisaic superiority, because of our possession of the wonderful law of cell modification known as *similia*, and deny that there are other methods of altering cell function? Should we not rather take the position of wishing the whole world to know its marvelous efficacy? Should we not also desire to know every possible way of modifying

cell function that has ever been taught, or that will be taught in the future? Is it not our bounden duty to our patients, to ourselves, to the glorious science of medicine, to know all that is knowable in every school, in every system? Are there not times when we use other methods of modifying cell function than the homœopathic one? Do we not, every day of our lives, modify cell function by other means than similia? If so, why not get down off the throne and admit that the subject ideas are capable of wonderful service in behalf of humanity? Is not this an argument in favor of the most catholic education in our colleges? Let us have all there is in medicine, and let the individual, who is responsible to no human being save himself, and next to his Maker, the wisdom of choosing the best method in a given case to alter cell function. You say, Why, we do teach medicine in all its branches. I admit that that is true; but you apologize for it, because you are in possession of one of the greatest secrets of healing in the gift of nature to give—similia. I myself believe in the most liberal education possible. Teach all there is in medicine, whatever its name, and teach the king of therapeutic laws, too, and fear not that that law will be overthrown. If it cannot stand its own ground, it had better fall. But you and I—for we have seen the beneficent action in the suffering—know that homœopathy would only come out of the contest with shining splendor and glory.

The fact that all therapeutic measures depend for their efficacy upon their ability to modify cell function brings me to the consideration of a dictum, framed by the illustrious founder of our school, that will not bear the glare of a common-sense view, and that is his assertion that “the totality of the symptoms constitutes the sole guide to the choice of a remedy.” The simple fact that cell function can be altered in various ways at once shows the illogicalness of this dictum. I grant you that, at the time it was enunciated, this proposition was the quintessence of wisdom. This formula does not at all impugn the truth of the law of similia, but is simply a rule of application that, at the time of its promulgation, Hahnemann thought was of the greatest importance. Those who believe in the literal truthfulness of this proposition of the Master’s, place a rule of procedure above the law that gave rise to it, and this

is not common sense. The law is supreme, even if the method of applying it is imperfect. At the time Hahnemann uttered this rule, it must be remembered that modern pathology had hardly been conceived, was certainly not born, and was a most heterogeneous mass of nonsense. In those days it was next to impossible to differentiate pleurodynia, pleurisy, pneumonia, intercostal neuralgia, phthisis, bronchitis. Think of bleeding a case of intercostal neuralgia, of purging phthisis, of hammering away at a bronchitis with remedies suitable for a pneumonia! Is it any wonder that Hahnemann, in his common-sense, decided that the totality of the symptoms was the sole guide in the choice of a remedy? That proposition, at the time, was like a ray of light across darkened and tempestuous waters, showing a haven to a shipwrecked crew, and, in those days, it was a safe way to apply the law *similia*. But in these modern days, homœopathy is unjustly robbed of the glory due her by a too strict and absolute method of applying the law of *similia*. Symptoms alone do not betray all there is in a remedy, and there is infinitely more power in a drug than is shown in its schema of symptoms. With our modern method of making the drug correspond to the pathology of the case we are extending the usefulness of the law, and we see that most of the definite so-called physiological drug actions are exquisite examples of *similia*. The acceptance of this dictum led indirectly to the teaching of a natural corollary, namely, that the diagnosis of the disease was a matter of indifference, so long as the totality of the symptoms of the case was obtained and the corresponding drug was given.

While I take off my cap to Father Hahnemann for his wonderful discovery and devotion to science, I cannot help but feel he was napping when he let that corollary get into his work. If the proposition that all medicinal action is dependent upon the ability to modify cell action is true, it follows that we must diagnose our cases, in order that we can tell what kind of cell modification we want. We must diagnose the case, and that gives us the key to the pathology, and the pathology tells us what kind of morbid cell action is taking place. Then and then only are we prepared to say whether a given case wants homœopathic treatment, surgical treatment, electrical, dietetic, hygienic, chemical or what not. When we have diagnosed the

case we will know what kind of cell function we want to alter, so as to bring back health; or, if that is impossible, make the sufferer more comfortable. It is not possible to always diagnose the exact particular disease to which a group of symptoms you are considering belongs, simply for the purpose of giving a name to the malady; but it is possible to *diagnose the condition*, and that, possibly, is the higher diagnosis. It is an easy thing to discover a valvular disease of the heart. It is a difficult thing to tell whether that heart is competent to perform its functions, despite its defects. This is the higher diagnosis. But this illuminating diagnosis is not possible to those who do not know how to diagnose disease in general, and rely upon their selected remedy to perform the miracle of removing all the symptoms independently of their nature, origin or pathology. Such prescribing is working in the dark with a vengeance, is limiting the field of usefulness of similia, kills diagnosis, pathology, clinical experience, hygiene, rational prognosis, and gives a false sense of security to the prescriber, or makes him appear like a clown with bells when his medicine fails. With a rational diagnosis as the basis of his prescription, he will know that it is beyond the pale of common sense to demand of the law similia that it cure incurable cases. He is virtually damning his own beneficent law when he asks his drug, prescribed symptomatically, to do what the Divine Maker of that law never intended should occur. There are miracles enough possible to medicine without demanding of it that it shall cure everything simply because the symptoms correspond to a certain drug. The wheels of progress in medicine will be held by such methods. The prescribing according to the totality of the symptoms is but one way of modifying cell action. To pursue it exclusively means a dearth of therapeutic measures. A drug should be known in all its capabilities, whether chemical, so-called physiological, according to similia symptomatically and according to similia pathogenetically. We should be able to cut with the point, the back, or either edge of the therapeutic sword; and the hilt of that sword should be able to take in the kid-gloved, dainty hand of the drug knight or the huge paw of the Viking in medicine. We, as homœopaths, owe this development of drugs in their entirety to humanity.

Hahnemann enunciated a truth that, it seems to me, will

never be swept away by any progress possible to medicine. He taught that the smallest curative dose should be given. That proposition bursts with its weight of common sense. But there is some dispute among us as to the smallest curative dose. The truth of the potency question is still under discussion; but there ought not to be the slightest difficulty about the application of this rule. The smallest curative dose may be of such a high dilution as to make the stars dizzy in its upward flight, or it may be two barrels of the fluid extract. The law is not affected by such variations. Every drug, it is common sense to conceive, is a law unto itself, as to its powers in crudeness or dilution, and no general rule applies. Another point ought to be taken into consideration here, too, and that is that every patient is a law unto himself in regard to the drugs that affect him. He may be able to take twenty drops of the tincture of nux vomica at a dose with benefit, and yet one drop of belladonna may produce aggravation. It would not be common sense, however, to refuse to give his next-door neighbor five drops of belladonna for fear of doing him harm. In other words, we must not base a rule of action on exceptions. The question of dose in a given case will always be a matter to be decided by the reaction of the patient to the medicine, and not by arbitrary preconceived rules. There will never be a time, therefore, in the history of medicine, when patients will not show idiosyncracies to drugs; there will never be a time when it will not require exquisite judgment to adapt the dose to the man. You cannot settle a matter of this kind by the microscope. They tried that down in the cultured Hub, and sent forth the dictum that, because they could discover no physical evidence of the existence of medicinal substance in any potency beyond the sixth, therefore there existed no medicinal power. The position was a wrong one. It established the microscope as the arbiter of the question. The common sense verdict should have been: "There is no medicinal virtue here, so far as it is in the power of the microscope to discover." A more powerful instrument might have shown different results; but whether it did or not is really a matter of the profoundest indifference to practical medicine. *The only arbiter of the efficacy of any drug, of any medical measure, of any therapeutic procedure, is the court of clinical experience.* The only jurors competent to sit in this

Court of Clinical Experience are men who are thoroughly educated clinicians, men who are saturated with medical knowledge and instinct from the crowns of their heads to the soles of their feet, who are steady-headed and brave-souled, and who love nothing so well as truth. The chameleon mentalities of medicine, the men who are too enthusiastic, the men who are narrow-minded, the men who have theories to prove, are not competent to act as jurors in this court of final appeal. Before this tribunal, sooner or later, must appear every theory and procedure in medicine, and in many cases the Scotch verdict of not proven, or guilty, or not guilty, will be rendered. The wish of every honest man is, let truth prevail.

There is another proposition of Hahnemann's that time and future investigations can never overthrow, and that is his dictum that every case must be individualized. To every clinician this is an everyday truth. No matter what the disease, when it attacks a man that malady is modified by the man it attacks, and it is the patient who is to be treated, and not the disease; for who has not seen pneumonias that were no more than a sore toe to the individual, and who has not seen patients with pneumonia, who at the first glance has not said this case will end fatally? Bronchitis is a simple disease to most people; but to some persons, owing to constitution or accompanying disease, it is as dangerous as double pneumonia and typhoid fever combined. The patient will always be the acme of therapeutic endeavor. If this proposition be true, it is common sense to know that this hunting after specifics for diseases is a delusion and a snare. There never can be a specific for a disease. We are wasting valuable time in such a search. We will find specifics for conditions, but not for named diseases. Finding the conditions present in the patient we need not care whether the disease be diphtheria, typhoid fever, septicæmia, or what not. This self-evident truth has led many to ignore nice diagnosis; but that is a mistake, for refinement in diagnosis will lead to discovery of new conditions, and hence new specifics, and our therapeutic armamentarium will become more powerful, and we will then be able to cure some diseases that we now regard as incurable.

This brings me to a new phase for the exercise of common sense in the practice of medicine. How many of us are startled

at the appearance in a case under our care of some so-called pathognomonic sign of grave or necessarily fatal disease? We sometimes lose heart, and give up all hope of effecting a cure. There is entirely too much pessimism in medicine to-day in regard to quite a number of maladies that are essentially organic in their nature. For instance, there is the group of diseases we know generically as Bright's. There was a time when, if I discovered a few tube casts under a microscope, I could hear angel wings rustle; but that time has gone by, for I have seen patients live many years whose urine constantly showed casts. True, casts are significant, but there are other urinary factors that are of graver import still. To gain a more practical idea of these so-called diagnostic factors in Bright's, I one summer made urinary analyses of all my patients, independently of the nature of their maladies, and found casts in ninety per cent. of the cases. Did they all have Bright's disease? I trow not! and yet it is not impossible that the disease may have existed in a slight degree, but not sufficient, in most cases at least, to produce *kidney incompetence*. If we accept casts as indubitable evidence of the existence of Bright's disease, we would be lacking in common sense if, from the presence of a few casts alone, we decided at once upon *the gravity* of the lesion. We do not understand all about casts yet, and it is a fatal blunder to base deductions upon false premises, and virtually assume that our knowledge in these matters is final and complete. Even now the position I take is that by casts alone, admitting for argument's sake that they are positively diagnostic of a kidney lesion, I may know of the existence of the disease, *but not of its extent*, nor of its *power to seriously compromise the health of the possessor of the casts*. Just here, too, let me say that Bright's can sometimes be more successfully diagnosed clinically than by the use of the microscope, although I would not like to do without its aid in many instances. Several times I have diagnosed Bright's in persons whom the urinary analysis showed to have perfect kidneys, and yet the post-mortem betrayed only too plainly the cause of death to have been uræmia.

So, the discovery of the tubercle bacilli in a single specimen of sputum is not positive evidence of the existence of pulmonary tuberculosis. It is only one sign, sometimes absent, and never pathognomonic.

There are some points, too, about the bacteriological diagnosis of diphtheria that leave much to be desired. Personally, I can only diagnose the disease by taking into consideration all the factors in the case. Certainly, the microscopic growth has been discovered in throats that were not clinically diphtheritic, and has not been found at all in cases that were pre-eminently and fatally diphtheritic. Besides, one of our throat men found the bacillus in about fifty-five per cent. of cases that appeared in a dispensary for treatment for ordinary troubles of the nasopharynx, and who showed no signs whatever of diphtheritic infection.

There are numberless other instances that could be quoted *ad libitum*, to show that it is common sense to believe that there are no absolutely pathognomonic signs in medicine, and that success in diagnosis is dependent upon the ability to grasp *all the phenomena present and weave them into a consistent and logical whole*. This makes our work the harder; but our science demands it, our patients demand it, our skill as therapeutists is enhanced by it.

We can never afford to be careless in diagnosis, for real advances in therapeutics cannot be made without clinical experience, and clinical experience must often revise her conclusions because of faulty diagnoses.

There is a duty we owe the public, and a sacred one at that, and that is not to incorporate into law any theory or procedure in medicine until its utility is established beyond peradventure. As an instance of the warping of public sense by the medical profession, let me mention the fact that in some communities the use of antitoxin in diphtheria is rendered compulsory. Such laws are utterly opposed to common sense, and are a danger to the community, for they rob the physician of his independence in thought and action, and compel the use of a medicament whose utility has not demonstrated its usefulness to the major portion of the profession. Whatever robs the individual physician of his right to use his judgment in a case of disease practically renders him incompetent to enter the sick-room, for every case of illness must be individualized as to what shall be done for it, and it might be the worst possible thing for that case to give the law-prescribed remedy. Again, I aver there are no such things as specifics for diseases, for

from year to year maladies change in their essential nature and mildness and fatality, although the group of symptoms called the disease still receives the same name. Any man who knows anything whatever of practical medicine knows that there is such a thing as the epidemic remedy, and that where he has obtained signal success with a certain medicine during the prevalence of a given epidemic, that remedy in subsequent epidemics has been as useless in the control of the symptoms of the disease as so much filtered water. The name of the disease was the same, the name of the medicine was the same, but the disease was not the same.

There are numberless instances, too, where health-laws work great harm to the individual, and do not adequately protect the community. The law compelling vaccination before a child is permitted to enter the public schools often works wrong to subjects unfitted for vaccination. In the absence of a malignant epidemic the family physician should be the arbiter of the question of vaccination or no vaccination, rather than the cold and indiscriminating law, which, by the very brutality of its wording, has arbitrarily declared that vaccination is harmless. It is not harmless. At best, it is the lesser of two evils; that is all. In a recent scare in my city we had, I believe, about six cases of smallpox, all isolated in the Municipal Hospital. The disease had attacked the vaccinated and unvaccinated alike. There was a great furore to become vaccinated at once. In most of my families I absolutely refused to pander to the scare by vaccinating. The last three or four epidemics of smallpox have been so mild that Dr. Welsh found it difficult to keep the patients in bed more than one or two days at most. To the more intelligent of my patients I gave this reason for my refusal to vaccinate. I said, "We have nearly a million population and six cases of smallpox, and the chances of your children catching the disease are even less than six chances in a million, for those six cases are isolated." Now, it seems reasonable to suppose that if you vaccinate, say, nearly two hundred thousand persons, suitable and unsuitable, as a preventive measure, you would have more deaths, directly and indirectly, as the result of that procedure, than if you had had twenty cases of smallpox, all ending fatally. Vaccination is deemed so harmless that no attention is given the general health of an

apparently healthy applicant for vaccination. Here the basis of the law, which is supposedly the greatest good for the greatest number, would certainly be violated.

There is another field directly connected with medicine where it is imperatively demanded of the medical profession that common sense be exercised, and that is in our relations to the pharmacists. They must furnish us with drugs of standardized strength, and the old plan of selecting a plant because it has all the appearances of being a good one, and all the odor, and all the general physical properties of the drug, must be abandoned. We must weed out the inert or almost inert drugs. We must not be allowed to discover their inertness first in the sick-room, as we are often compelled to do nowadays. It is not a question of cost, for our drug weapons must be reliable. Either chemistry or proving must discover for us the virtue of the medication. This is no hardship to the honest pharmacist, and him only do we expect to reach, for the other kind, who dispenses patent medicines over the counter, ought to be outlawed to protect the public. The time has gone by when we should accept any but the most positive scientific evidence of the existence of drug potency. Nature is not alike all years. She sometimes produces imitations. We must discover them before they become weapons in the sick-room.

The wonderful advances made by specialism in medicine in the last two decades is one of the greatest glories of the profession. There is a possible danger, however, that specialism will be carried too far, and we must use our common sense to prevent disaster from following where only good should come. Specialism has developed along special lines; but we must not let the part dominate the whole, for the specialism that does not recognize that it is but simply the handmaid of general medicine is bound to wreck itself by its own folly. Man is a congeries of organs, and every organ is dependent and interdependent upon the action of the other, and the whole man must be recognized by any specialty worthy the name. We do not want a throat man hammering away at a mild nasal catarrh while the man's heart is dilating. We do not want an eye man to believe that every disease under the sun results from eye strain. We do not want a gynecologist to treat a mild cervical catarrh heroically, as if it were the whole disease

picture, when the patient has a Bright's. In other words, common sense demands that, whether specialist or general practitioner, he shall be a doctor all over, and from the ground up and from the head down. The general practitioner must be more of a specialist, and the specialist more of a general practitioner. We must learn to keep our hands off as well as to put them on. Our surgeons—God bless them! for they need it—must learn to be better doctors, and our general practitioners must learn to be that greatest kind of surgeon, according to Senn, a doctor who knows when and how to cut.

Our lay friends need not be entirely idle in the good work of aiding the medical profession. They, too, can exercise that supreme gift of common sense in ways that will be effective. For instance, they demand that their doctor shall have had a good general education, have studied a year with a preceptor, attended college four or five years, had a year or two as resident physician in a hospital, and passed a State Medical Board of Examiners, and, if he is a real good fellow and you would like to see him get along, after he has had his sheepskin for ten years you will let him prescribe for one of your servants; and yet some of you will take medicine, and pay a good round sum for it, too, from some butcher or baker or candlestickmaker who thinks he knows what is good for sick people, and who advertises it—a thing you would abominate and would not tolerate in your own doctor, for you prefer that he allow you to praise him, and do not like him to waste his talents trying to blow his own horn.

It is not common sense to demand so much education from the doctor, and the expenditure of much time and money, and at the same time allow any Tom, Dick or Harry to place any sort of secret compound on the market without let or hindrance, and without the expenditure of a sou marque to secure the necessary qualifications. Quackery disregards the essential principle of the successful use of drugs, the individualization of the case.

The laity, too, need not be too brave in forming anti-vivisection societies, for a true investigator is ever humane, and many animals that are experimented upon are placed under the influence of an anæsthetic, and they frequently get up from the experimenter's table and gambol around in play. Even were

this not so, we will assume that it is common sense to conclude that the lives of the lower animals are not as precious to them as they are to us, when they teach us great truths in anatomy and physiology, in inoculability to disease, in susceptibility to drug action, and in cerebral localization. Most of the marvellous advances that have been made in abdominal and cerebral surgery have been preceded by experimental studies on the lower animals. Thousands of precious human lives have been saved to their loving ones by this study. The abdominal cavity and the cavity of the brain were once the sacred ground that no air dared reach else death stalked in. We have demonstrated that this was incorrect reasoning, and humanity has been the gainer and the animal ennobled by furnishing the key that unlocked the knowledge that made this possible.

We have said much about common sense to-night, and might say more, but the very acme of common sense is the conception that human health is often in your keeping, and that by the exercise of the powers your Maker has given you you can often save life, can many times prolong it, and can always ameliorate and deaden inevitable suffering, and a calling holier than this no man need want. You should feel the dignity and the enormous responsibility of your position and press on to new conquests. You can hold grim death at bay, but he will finally conquer; not only your patients, but you yourselves will taste of that bitter sweetness that comes to all. When the end comes, approach the final plunge without fear. He who has painted the lily, put perfume on the violet, swung the gleaming stars in space, and let His sun shine on the evil as well as on the good, will surely give us a welcome to a brighter world than this.

BEER YEAST FOR CHRONIC CONSTIPATION.—According to Dr. E. Roos, privat docent of internal medicine at the Medical Faculty of Fribourg, beer yeast seems to exercise a most favorable influence upon chronic constipation. The fresh beer yeast, simply dried at a temperature of 30°, suffices, and then 0 gr. 50 centigrams per day should be taken two or three times, or the beer yeast could be heated at 130° for an hour; in this instance half of the previously prescribed dose would suffice. This substance acts as a laxative owing to the chemical composition which stimulates the peristaltic action of the bowels. While almost at the second day after taking the beer yeast the bowels would respond favorably, yet it will be noticed a slight tympanites, slight colic, but this could be overcome by using the second mode of preparation, that is by heating it at 130° in a hot chamber.—*Semaine Medicale*, October, 1900.

FRACTURES OF THE LARYNX.

BY HARRY S. WEAVER, M.D., PHILADELPHIA.

(Read before the Philadelphia County Homœopathic Medical Society.)

THE larynx may be injured either internally, by the entrance of foreign substances, solid, liquid or gaseous, or externally, by contusions, punctures or incisions.

This paper will simply take up injuries by contusions, which are made by external violence from non-cutting or non-puncturing substances.

Simple contusions of the larynx, which show but slightly externally, at times involve the deeper tissues sufficiently to cause violent and destructive inflammation, followed by œdema of the epiglottis and arytenoids, endangering the life of the patient unless prompt and efficient surgical aid is rendered.

In all cases following even the slightest injury to the larynx, an immediate and thorough examination should be made, as more would probably be revealed then than later, owing to the swelling of the parts.

The more severe contusions, which cause not only a bruising of the superficial tissues, but a fracture of the hyoid bone or some of the cartilages, or more rarely a dislocation, have sufficient urgent symptoms to call for a careful examination.

The mortality in fractures of the hyoid bone or to the cartilages of the larynx or to both combined is very great, ranging from 75 to 95 per cent. The case I wish to present to-night represents one of the extremely rare accidents which may occur to the laryngeal box, with some very interesting sequelæ.

Miss C., 40 years of age, a teacher by profession, while driving on July 12, 1900, was thrown from her carriage, and as she fell either struck the rim of the wheel with her neck or, more probably, was thrown in front of the wheels, one of which passed over the arm, across the chest and neck, causing a severe contusion of the superficial tissues of the neck and a fracture of the right cornu of the hyoid bone and of the left

thyroid cartilage, and considerable displacement of the contour of the vocal box.

For a few moments the patient was completely dazed, and on regaining her senses found she could not speak. Feeling something in her throat which she thought to be mucus, she expectorated, and was much surprised and alarmed to find a quantity of bright red blood.

She was conveyed to her home, and Dr. Quimby, the family physician, distinctly outlined a fracture of the hyoid bone and of the left thyroid cartilage, which they succeeded in setting in proper position, holding them firm by adhesive strips and a pasteboard splint curved to fit the neck. These were securely fastened by means of a bandage, and the patient kept as quiet as possible until the hæmorrhage, which lasted thirty-six hours, ceased.

During the first twenty-four hours the patient at long intervals swallowed saliva, but this moved the fragments, and when told that the process of deglutition would interfere with her recovery, she determined not to swallow, a resolution to which she adhered in the strictest sense, not swallowing even her saliva for a period of three weeks.

During this time the only nourishment obtained was from nutritive enemata, which were sufficient to sustain life and prevent undue suffering from thirst.

At the expiration of three weeks she was given small quantities of milk at frequent intervals, in conjunction with the nutritive enemata. During this time she lost in weight twenty-five pounds.

As her voice was her means of living, she became anxious as the days passed, still leaving her speechless, and, as I had treated her for some former throat trouble, she requested that I be called in consultation.

I was in Europe at the time, so my brother saw the case with Dr. Quimby seventeen days after the accident. He found the tissues about the larynx quite œdematous, and the rim of the larynx irregularly shaped, with a laceration of the mucous membrane on the left side above the vocal bands. Taking all things into consideration, a guarded prognosis was given.

An August 18th, five weeks after the accident, my brother saw the patient a second time, at the office, and advised her to

make arrangements to remain in the city for treatment. This she did, and on the 23d he and Dr. Shallcross went over the case and decided upon the use of electricity.

From that time daily treatments were given, which gave some relief from the dyspnœa and pain, and gave increased mobility to the tissues over the seat of fracture. These were continued in connection with some remedies which were given internally, until my return on September 14th.

Upon my first examination, I found the swelling of the epiglottis nearly gone, but on the left side of the larynx a mass of mucous membrane detached from the cartilages of the larynx and bulging toward the median line; also a laceration of the left false cord, and inversion with prolapsus of the left ventricle, which hung down between the vocal bands, covering completely the left and greater portion of the right, and filling all except the posterior portion of the larynx, through which she breathed.

Her dyspnœa was exceedingly severe, at times, from the day of the accident, but always less labored when lying on the left side; but at times was so severe that each breath seemed to be her last.

What probably saved her life in some of these attacks was her knowledge of the correct manner of breathing and the proper use of the muscles of the throat.

I continued the application of electricity for two days, but, as she complained of a return of the pain, decided that something else must be done.

I told her that in all probability an operation would be necessary, to which she consented; but, on thinking it over, I determined to try, first, some inter-laryngeal astringent and absorbent application, and on September 16th applied glycerine and iodine, 5 gr. to 1 oz. of glycerine, directly to the bulging mass on the larynx.

Never have I more reluctantly or hesitatingly made a laryngeal application than in this case, fearing a spasm or more relaxation of the bulging tissue on the left side, which would shut off her breathing completely.

I had made all preparation for a hasty tracheotomy should this occur. The application was followed by a moderately severe attack of dyspnœa, which was soon over.

When I saw the patient next morning she said she had rested well all night, and that her breathing was easier; her larynx showed signs of improvement.

I continued the same application daily until October 4th, when she produced the first audible sound since the accident, a fairly distinct "a."

Three days later, as I admitted her to the office, with a face wreathed in smiles, she said faintly, but distinctly, "Good morning, Dr. Weaver."

These applications were continued until October 17th, when she had a slight hæmorrhage of bright red blood, preceded by severe pain on the right side of the throat, which the hæmorrhage relieved. For this reason I changed the application to chloride of zinc, with belladonna internally, for two days, after which I returned to the glycerine and iodine, with phosphorus internally, her voice gradually but steadily improving in strength each day. The mass on the left side gradually became smaller, so that a view of both cords could be seen, and on October 24th thuja was applied and thoroughly rubbed into the remaining hypertrophy. This was followed by a slight bloody expectoration, for which hamamelis was given for a few days. Glycerine and iodine was again used in connection with phosphorus until she went South to Tennessee, on November 16th, to resume her work as a teacher.

The contour of the larynx was nearly normal, but there is considerable thickening of the false vocal cords, and in the anterior commissure there was remaining a slight projection, which, up to her departure, did not disappear.

I received a letter from her a few days ago, stating that her throat was in good condition. Her first assistant was ill and she was compelled to do double duty, from which she felt no ill effects.

TREATMENT OF PNEUMONIA WITH BREWERS' YEAST.—At the meeting of the French Medical Society, May, 1900, *Marie* reported on the treatment of pneumonia with brewers' yeast, given in the same doses as in furunculosis. Eight cases, some of them severe, of pneumonia and broncho-pneumonia were cured by its use.

Frisans praised the effects of brewers' yeast in daily doses of three to four teaspoonfuls in cases of influenza and typhoid, and recommended it as an excellent disinfectant of the gastro-intestinal tract. Had obtained no results from its use in pneumonia.—*Wiener Med. Wochenschrift*, No. 4, 1901.

CREASOTE CARBONATE IN BRONCHO-PNEUMONIC PHTHISIS.

BY FRANK H. PRITCHARD, M.D., MONROEVILLE, OHIO.

I SHOULD like to call attention to a remedy which, though probably not acting according to the law of similars, appears to fill out such an apparent void in therapeutics as to be worthy of notice. That drug is the carbonate of creasote, or creasotal. Now and then one meets with a case of measles, grippe, and especially whooping-cough, where the child, probably previously spindling and delicate, though not always so, does not do well. He is seized with what seems to be a beginning alveolar pneumonia, his temperature runs up, his pulse becomes rapid and thin, his tongue becomes covered over with a yellowish white coat. He rapidly emaciates, and, in short, appears to be doing badly. If one takes his temperature it will be seen to be at 104° or 105° , with a drop of a few degrees in the forenoon. The mother will tell that he has been sweating at night, generally quite profusely. Such children are by no means always spindling, for an area of tuberculosis may be so closed in as not to interfere with the general nutrition. However, these children will usually come from slender and spindling parents, with a history of an occasional case of consumption amongst the relatives. The cough is usually quite distressing, with profuse expectoration of a whitish, yellowish, or even of a blood-streaked sputum, which, however, is not the rusty expectoration of lobar pneumonia. The child's temperature keeps up at times for days, commencing to rise at noon to two in the afternoon, and continuing to go up until late in the evening, though from midnight on till morning it usually falls, at least later in the disease, with profuse sweating. For days the fever may run along at 104° or 105° , and even 105.5° , with rapid emaciation, lack of appetite, and a look in the patient's face and body as though he were melting away.

Such patients usually present the physical signs of a bron-

cho-pneumonia, though one may often be able to outline the original focus in the apex, or more usually in the base of one lung. It is curious how often one finds the bases of children's lungs affected in tuberculosis. There may be an area of dullness, with numerous sub-crepitating râles, and a bronchitis leading from that spot. Later, if the disease is gotten under control, the disease becomes narrowed down to the original area. Such children are very difficult, at least for me, to treat, and this tuberculous affection is liable to end in death, though by no means as often as the books teach us. In such cases I have found creasotal to be a remedy which reasonably and rapidly takes these cases in hand and leads them upwards instead of downwards. In a dose of one to five drops every two to three hours it soon controls the temperature, pulse, toxic poisoning, and, in short, curbs the whole process in a way that is very satisfactory. As soon as the tongue begins to clean and the appetite to pick up the remedy may be given at longer intervals. Iodoform 2x I have at times administered, along with the creasotal, yet I think that it is secondary in importance.

The temperature in these cases is quite peculiar. In some it is irregular—at times low, then away up again; though usually the type of tubercular fever, with the 2 to 4 p. m. rise, is generally to be made out. In others it may be normal, almost normal, or even subnormal, in the morning and forenoon, with a chill towards noon and a rapid rise, the child lying in a typhoid state, stupid and hard to arouse until about 6 o'clock, when he may waken and get up, at least during the beginning of the illness. He usually begins to sweat as the fever commences to fall. Such a clinical picture at first sight looks like an intermittent fever; but in a child, along with grippe, measles, and, above all, whooping-cough, I have learned to be on my guard against acute broncho-pneumonic phthisis. I remember one little fellow of six years who towards the end of an attack of whooping-cough began to suffer from what seemed to be malarial chills, and that at the season when we have them in this region, though they are by no means frequent. I tried various remedies, and finally, in a desperate desire to accomplish something, I gave him as much as eighteen grains of quinine a day, but with no results. I looked him over again, and found a good-sized area of consolidation

at the base of the right lung, filled with sub-crepitant râles. He received creasotal, with iodoform 2x, and did well.

Such children, even little girls, have an abnormal development of hair on their bodies, particularly on the chest and back. There is an old medical proverb in Latin current amongst the French clinicians—*puer tabidus, puer pilosus*. Their chests are thin and flat, the scapulæ standing with the tips outwards, like wings. Often one look at the chest of such a patient suffices to give one a diagnostic hint. Such children are, as a rule, poor eaters. The mother is obliged to coax and insist on their making a meal when they are at the table. They require good, hearty and simple food, with plenty of fat meat and vegetables. Cream and good milk are important items in their dietary. But above all things they need out-door air, and as much as they can get. It is a mistake to keep such children in the house during the winter days after they convalesce. They should be wrapped up and sent out or taken out. At night the windows should be sufficiently down to insure a good supply of fresh air. The children should be warmly clad in woolen underclothing. In short, it requires a knowledge of the disease and intelligence to combat the after-effects of this form of tuberculosis, if the patient is so fortunate as to escape. A very large number of them do have their tuberculosis arrested. Then follows the long battle of years to keep it arrested and to help nature "close it in," as the German writers express it. To this end good food, fresh air both by day and night, and, by no means last and least, creasotal, are the measures to be relied on. I have been in the habit of having the mother give from five to ten drops of this drug three to four times a day continuously, to keep these little patients well after they have convalesced. At the most, a greenish discoloration of the urine is the only sign of overdosing that I have noticed. Then the drug may be stopped for a few days or given in smaller doses. Residence in a warm and dry climate would, of course, be the ideal place for such patients, but not all can afford this. Winter is the time of worry and care for the parents of such little patients.

CONGENITAL ABNORMALITIES OF THE CRANIO-VERTEBRAL AXIS.

BY H. L. NORTHPROP, M.D., PHILADELPHIA.

(Read before the Philadelphia County Homœopathic Medical Society.)

THE first part of the embryo to begin its development is the neural groove of the cerebro-spinal axis, formed in connection with the chorda dorsalis, which lies in the long axis of the embryo and in which the cartilaginous bodies of the vertebræ are soon formed. The chorda dorsalis soon shrinks, except the portions left between the vertebral bodies, which become the intervertebral disks. The neural groove, quickly converted into a canal, the central canal of the spinal cord, is thus promptly supported by cartilaginous centres, from whose sides the cartilage extends backwards to finally unite and constitute the vertebral arch. A typical vertebra contains three primary and several secondary ossific centres. At birth the vertebra consists of three bony parts, a body, and two lateral masses, the arch, connected with the body by cartilage. This cartilage is not obliterated for several years after birth. Sometimes the union between the laminae of the arch is incomplete and a gap is left, constituting a common congenital defect.

It is an interesting fact that throughout the vertebrate series the part of the embryo to begin its formation is the cerebro-spinal axis, and that this all-important structure is early protected by a surrounding wall of bone and cartilage. Indeed, throughout the entire group of vertebrates the skeleton consists of bone, while the skeletal make-up of all invertebrates is never composed of true bone, but of shelly or horny material. True bone, therefore, is characteristic of the vertebrate.

It is further interesting to note that the vertebral column (and this cannot be said of any other part of the skeleton) shows the least tendency to go astray, if you please, and presents irregularities or deficiencies of development. Only in the most pronounced monstrosities do we find in it any special or material defect.

Pari passu with the fixed and determined efforts upon the

part of Nature displayed in the formation of this fundamental segment of our anatomy is the gravity of any lesion, congenital or acquired, of the cranio-vertebral wall. Occurring either before or after birth, such lesion is sure to affect the delicate meningeal and neural structures within. And, at the same time, difficulties of diagnosis, to say nothing of effectual curative treatment, are presented, while complications and sequelæ in such cases are often insurmountable. To illustrate, spina bifida, particularly spina bifida occulta, will prove the greatest menace to the health and life of the child so affected, and will go unnoticed—undiagnosed—by many physicians.

Again, a spina bifida capable of easy and prompt recognition will pretty surely be attended by serious complications, while treatment of the original or secondary condition may be attended by discouraging results.

Notwithstanding these difficulties, congenital lesions of the protective envelope of the cerebro-spinal axis, and associated congenital implantations, form a most interesting class of cases deserving scientific study.

Spina bifida is regarded as the commonest form of congenital anomaly; it occurs in about 1 in every 1000 children, and is located most frequently (three-quarters of all cases) in the lumbo-sacral region, where the medullary groove closes later than elsewhere.

In itself an indication of tardy and faulty development, it is naturally frequently associated with other abnormalities. Harelip, cleft palate, strabismus, talipes, or a defect in the wall of the cranium permitting some form of encephalocele, are often found. Hydrocephalus, paraplegia and sphincter paralysis may be present.

The several varieties of spina bifida are classified according to the make-up of the tumor: if only the meninges protrude through the defect in the bony wall, and are distended with cerebro-spinal fluid, the tumor is called a meningocele; if, in addition to the membranes, there is a protrusion of nerve fibres (usually the cauda equina), and of the cord also, the variety is known as meningomyelocele; if the central canal of the cord is contained in the tumor, is distended, and the neural wall is consequently thinned, the tumor is a syringomyelocele. The second variety is, unfortunately, the commonest.

The diagnosis of spina bifida is usually an easy matter. With a congenital tumor in the median line of the back, and quite likely in the lumbo-sacral region, elastic, growing tense with expiratory and straining efforts, and probably associated with congenital deformity of other parts, no error of diagnosis is permissible. Spina bifida occulta, where there is the congenital defect, but not the tumor, is more apt to be overlooked; but with congenital lesions of other parts, associated with a peculiar growth of hair over the seat of the bifida, the difficulty of diagnosis is minimized.

Differential diagnosis involves the consideration of many kinds of tumors which may develop over, or in connection with, the vertebral column; among the commonest are sebaceous cysts, lipomata, abscesses due to Pott's disease or other bone necrosis, and the different varieties of epiblastic cysts, dermoids, teratomata and implantation cysts. Less than a week ago Dr. W. B. Van Lennep removed a lipoma from the lower cervical region in the median line; if this had originated congenitally it would have caused the observer to at least think of spina bifida. Only a few days ago I enucleated an uncommonly large sebaceous cyst from over the lower part of the sacrum; if this had been a tumor of congenital origin it would have looked suspiciously like a spina bifida.

Again, diagnosis of the kind of spina bifida is essential in deciding upon the plan of treatment to be instituted. A meningocele must be dealt with differently from a meningomyelocele or syringomyelocele. A meningocele has a smooth, even surface, without a dimple or scar in the thin, poorly nourished integument covering it, and through which light is easily transmitted; a meningomyelocele or syringomyelocele usually presents a post-anal dimple caused by the attachment of the lower end of the spinal cord or of nerve-trunks to the under surface of the skin, which may contain a scar. It may be associated with paralysis of sphincters, and atrophy and paralysis of the lower extremities and club-foot, while light will be transmitted through the tumor with more or less difficulty.

As to treatment, English surgeons speak highly of the injection of Morton's fluid (iodine, iodide of potash and glycerine). Keen and other American authorities advise it in a half-hearted way. Bayer, who has reviewed the subject comprehensively,

rejects seton, injection of iodine, and excision of a part of the sac, as being "unsatisfactory and dangerous." He looks upon the condition as one analogous to hernia, and urges that it be treated in a similar manner, saying that the danger of meningitis is no greater in the one case than peritonitis is in the other. A careful perusal of the literature shows that operative measures are gaining ground, especially in meningocele. Personally, I have never used the injection method.

As to the time at which operation should be done, let postponement be the order of the day, if possible, in order to bring about development sufficient to produce a spontaneous cure, although such a consummation cannot be hopefully expected in many cases. If possible, no operation should be done under two or three months after birth—in other words, wait until improvement in both the local and the general condition has come to a standstill.

If the tumor is a meningocele and pedunculated (a rare condition, and often not demonstrable until radical interference is undertaken), excision is easy. Many and unique are the devices resorted to in the operation of excision, suggested naturally by the difficulties experienced in securing suitable substantial flaps to close the defects. Cases must be treated individually, according to the size and location of the gap in the vertebral wall. If the patient survives one operation, a second and even a third may be necessary to complete the cure.

From a list of five cases of spina bifida with which I have come in contact as consultant or operator, permit me to select the following as the most instructive and interesting: Grace S., $2\frac{1}{2}$ hours old; difficult breech delivery; hemispherical tumor $7\frac{3}{4}$ inches in circumference, $4\frac{1}{2}$ inches longitudinal and $4\frac{1}{2}$ inches transverse measurement, $1\frac{1}{2}$ inches in height, in median line at lumbo-sacral junction. Abrupt, bony edge easily felt around base of tumor, which is quite soft, elastic, without dimple or scar upon it, and covered with extremely thin integument, which is raw and bleeding from pressure and efforts at delivery of child. Tumor becomes more tense when child cries, and rises and falls perceptibly; light easily transmitted, and shows contents of sac to be of fluid alone. Child is undersized, has a peculiar, almost animal-like or cephalic cry, face has slight idiotic expression, head small, and sutures are closely approximated; fontanelles

are small. Lower extremities moved sluggishly; sphincters apparently not paralyzed. Diagnosis, meningocele (Fig. 1).

Advised support and protection of tumor by absorbent cotton and gauze bandage, making moderate pressure only, at the same time watching for convulsions or other symptoms of cerebral irritation. Aristol, dr. $\frac{1}{2}$, carbolized vaseline, 3 per cent., oz. 1, to be applied to denuded surface of integument.

The subsequent course of this case has been most interesting to me. The tumor lessened in size and tenseness under the pressure and the skin slowly healed, but the head began to in-



crease in all directions, the sutures separated widely enough to admit an adult thumb, the frontal or metopic suture became very apparent, and the fontanelles gaped widely. The attending physician thereupon removed all pressure from the spinal tumor and encased the head in a linen cap made to fit snugly, over which he applied adhesive plaster strips, thus securing firm and equable pressure upon the cranial contents. At the same time iodide of potash, 2 grains well diluted in water, was administered every three hours. Under this treatment, continued for six weeks, the tumor was reduced to the following measurements: circumference, $6\frac{3}{4}$ inches; longitudinal measurement,

3 $\frac{1}{4}$ inches; transverse measurement, 3 $\frac{1}{2}$ inches. The head assumed a much better shape, and decreased in size sufficiently to approximate all the bones, although even the posterior fontanelle persisted and was of considerable size.

Shortly after the birth of this little girl, synchronously with the enlargement of the head, a double talipes developed; improvement has also occurred here. Pressure over the tumor aggravated the talipes, which has improved since its removal. The sphincters, at one time since the birth evidencing weakness, have also regained their normal tone. The child is bright



mentally, has a better facial expression, and is "a splendid feeder." While sleeping poorly, cross and restless when lying in the horizontal position, she sleeps well and for two or three hours at a time if elevated to an angle of 45°.

The attending physician deserves all the credit for the improvement in this case, in which I have occupied but a subordinate position, although repeatedly advising against radical operative interference until it is forced upon us. As the improvement is still progressing, we are most gladly giving it a chance.

I cite the above case to illustrate what I firmly believe to be

the better mode of treatment of spina bifida, without special complications calling for immediate operation.

Interesting in this connection, from the standpoint of differential diagnosis, was a case to which I was called last September. Boy, at whose birth, four days before, soft, fluctuating swelling, size of silver dollar, was noticed above and to the left of external occipital protuberance. Labor was quite short and easy, the mother, a multipara, having but a few, short pains. Tumor increased in size, became lobulated, and involved both sides, as shown by accompanying photographs. Fluctuation unmistakable; light not transmitted. General condition ex-



cellent, and no evidences of anæmia or loss of blood. Advised aspiration, which I did under strict antiseptic regime, first upon one side of the head and then upon the other, removing ten ounces of dark, fluid blood. Applied bandage snugly with a view of making pressure, and suggested possibility of further aspiration being necessary, or incision and drainage, should infection occur. Reaccumulation of the fluid took place in twenty-four hours, but further operation was deemed unnecessary because it was found that by laying child upon the side the tumor was made to completely disappear for the time being upon that side, and then, by reversing the position, the opposite side of the head was decreased in the same way. After this pressure

had been continued for a week or ten days, the swelling ceased to appear.

What was this tumor? Surely, not the usual *caput succedaneum*, because of the total absence of *œdema* and of the characteristic bogginess of the scalp tissues, and hardly to be looked for after so short and easy a labor. In this case the collection of fluid was between the scalp and the bones of the cranial vault. Because of the absence of pulsations and peripheral nervous symptoms I excluded *encephalocele*. I likewise excluded *meningocele*, because of the rarity of this variety of congenital cephalic tumor, absence of translucency and pulsation, the fact that it was without pedicle and not reducible. I was somewhat suspicious of *hydrencephalocele*, because it is the commonest of congenital cephalic tumors, the large size of this one, its lobulated condition, absence of pulsations, non-reducibility, and absence of translucency. Beyond this suspicion of the bare possibility of *hydrencephalocele*, there was practically nothing for this tumor to be but a *hæmatoma*, and such it was. What bloodvessel furnished this hæmorrhage, and continued to furnish it for nearly two weeks? The blood was probably venous, although we know that arterial blood retained in a quiescent condition for a number of hours or days will become dark in color. Perhaps it came from a vessel in the scalp tissues, such as the occipital artery or vein, which may be a branch of considerable size, but hardly large enough to produce such an extensive extravasation. Moreover, the collection in this case was not in the scalp, but beneath it. I cannot help but feel that it was an escape from one of the emissary veins of the cranial sinuses, probably a mastoid or parietal vein of unusual size, which was torn through during the delivery.

As an associated congenital deviation from the normal, I will now briefly refer to a class of cases frequently met with in connection with sacral and coccygeal surgery, viz., that peculiar epiblastic redundancy commonly called a dermoid cyst—perhaps more correctly entitled a dermoid. By reporting two cases of this character the subject will be sufficiently dealt with.

CASE I.—Male, age 28 years. Three or four months ago noticed soreness and small lump one and one-half inches back of anus, in internatal fold, which broke and has discharged more or less pus ever since. His physician quite naturally

diagnosed the condition as fistula in ano, and endeavored to obliterate the channel by applying caustics,—nitrate of silver and carbolic acid. Exquisite sensitiveness and lack of improvement hastened a radical operation, which I performed under ether.

A probe introduced into the sinus was carried, not toward the rectum or anal canal, but directly backward and upward to the lower part of the external surface of the sacrum. Upon opening this sinus freely a small cavity at its upper end was exposed, and found filled with masses and coils of hair embedded in pus and sebaceous matter. Diagnosis, of course, was obvious.

CASE II.—Male, age 23, tried to jump over a fence four months ago, but caught on a rail and fell, striking lower end of back. One month later a swelling appeared over sacrum, became painful, and broke through opening two inches behind and to right of anus. Family physician naturally diagnosed sinus due to necrosis of sacrum or coccyx, result of injury four months ago. *Status præsens*: Slight discoloration and induration near base of sacrum. Sinus opening, two inches behind and to right of anus, filled with exuberant granulations and oozing dirty, green pus. The introduction of a grooved director shows sinus extending upward and backward toward above-mentioned discoloration over sacrum, at which latter point is a flattened cavity three inches in transverse diameter, containing several masses of hair and evidences of epithelial débris.

These several cases are offered to you to-night because of the relationship which they bear to one another in many respects, but particularly because they bring directly home to us the importance of at least a correct diagnosis when dealing with congenital abnormalities of the cranio-vertebral axis.

LACHESIS TRIGONOCEPHALUS IN SEPTIC PAROTIDITIS.—The suggestive paper, by Dr. H. F. Biggar, of Cleveland, upon the curative powers of our lachesis in this fatal complication of septic infection is one that deserves careful reading by every surgeon in our school. There is very little literature upon this condition of the parotid gland. He gives in detail the histories of five cases of septic parotiditis, and believes that, while sustaining treatment is very necessary, *lachesis* is a curative remedy.

The author's results were certainly quite remarkable and very brilliant. He used the 6x and 30th dilutions.—*N. A. Journal of Homœopathy.*

ACETONE AND DIACETIC ACID IN DIABETES.

BY CHARLES PLATT, M.D., PH.D.,

Professor of Chemistry and Toxicology, Hahnemann Medical College, Phila.

It has long been recognized by physiological chemists that when a glycosuric develops an acetonuria or a diaceturia the prognosis is, generally speaking, more than usually unfavorable. This fact has recently excited some attention among clinicians, with the result that there has been more frequent testing for acetone and diacetic acid in diabetic urine, but the true significance of these substances in the urine has not been commented upon in the journals. The unfavorable prognosis has been accepted, while the etiology of the condition has been left unstudied. Such a position is unworthy of scientific medicine. What are these substances? How are they formed? What relation do they bear to the sugar? Why should their appearance in the urine warrant a less favorable prognosis?

Acetone may be made in the laboratory by the oxidation of simpler compounds, or by the hydrolysis of more complex compounds. Long ago it was held responsible for diabetic coma; and now, while we know it to be incapable of such an influence, we still find it increased in many cases of advanced diabetes. It is, however, often present in considerable amount in the absence of coma, *e.g.*, in the urine of the acute infectious fevers, in cachexia, in mental debility with abstinence, and in such other widely differing conditions as lesion of the sinus fovea rhomboidalis and disturbed digestion. Acetone is, in fact, normally present in the urine; and, as with urea, creatinin, etc., it is the abnormal increase only that need excite comment.

Aceto-acetic acid, commonly called diacetic acid, is interesting as the immediate source of the acetone. Like acetone it has been regarded as the cause of diabetic coma, but, like acetone again, it has failed to stand the physiological test, and, while frequently associated with the comatose state, it can be regarded as an incident only, not as the cause.

A step farther in the investigation brings us to β -hydroxybutyric acid, in turn the progenitor of diacetic acid, as is the latter of acetone. Here again we have a substance to which has been attributed the diabetic coma, and with more truth, this time, for β -hydroxybutyric acid is distinctly poisonous. It cannot, however, actually produce the condition, and for the true causative agent we must look to that substance from which the β -hydroxybutyric acid is derived, namely, to the β -aminobutyric acid found in the blood. It will be seen, then, that we have a series of substances, starting with β -aminobutyric acid, which by loss of its amidogen radical is converted into β -hydroxybutyric acid, and as such excreted, along with the more complete decomposition products, diacetic acid and acetone. The chemical relation of these substances is shown by their formulæ :

β -aminobutyric acid,	.	.	.	$\text{CH}_3, \text{CH}, \text{NH}_2, \text{CH}_2, \text{COOH}.$
β -hydroxybutyric,	.	.	.	$\text{CH}_3, \text{CH}, \text{OH}, \text{CH}_2, \text{COOH}.$
Aceto-acetic acid,	.	.	.	$\text{CH}_3, \text{CO}, \text{CH}_2, \text{COOH}.$
Acetone,	.	.	.	$(\text{CH}_3)_2, \text{CO}.$

The first step in the change involves the splitting off of an amidogen (NH_2) group; and, as may be expected, we find associated an increase of urea, $\text{CO}(\text{NH}_2)_2$.

Accepting the β -aminobutyric acid (probably with similar but as yet undetermined substances) as the cause of the coma and allied manifestations, how is this compound related to sugar, and how is it produced within the body?

It will probably be granted by all that glucose in the urine is not necessarily, nor indeed often, derived from the carbohydrates of the food. The more frequent origin in proteid decomposition is now sufficiently proven. The proteid—in diabetes probably that already forming part of the body tissue—is decomposed, the molecule yielding as one of the decomposition products the carbohydrate. But the proteid molecule is wonderfully complex and capable of diverse decompositions. Under conditions of abnormal katabolism we find, for instance, many highly poisonous leucomaine-like substances appearing; and here, among these, we place our aminobutyric acid, not as a leucomaine, be it understood, but as a poisonous product similar in its physiological possibilities.

We can therefore appreciate the fact that the appearance of acetone, diacetic acid, etc., in the urine must be associated with conditions of abnormal metabolism. We realize that they originate in unnatural, or at least exaggerated, proteid katabolism, and that in this respect they are of similar origin to the sugar itself. We understand the wasting in diseases associated with hydroxybutyric acid in the urine, and, we *should* understand, also, the necessity for maintaining the body metabolism in as near a normal state as possible, that these poisonous substances may not be formed, or, if formed, then only in such small amount that they may be completely oxidized, and thus rendered harmless.

Body metabolism cannot be maintained at a normal on an abnormal diet. It is true the body has a wonderful power of adjustment, but abnormal conditions can be met successfully for brief periods only. What, then, is the effect of the usual diabetic diet? No fact is so well established in all physiology as that the body requires a certain definite proportion between the nitrogenous and the non-nitrogenous or carbonaceous components of the diet. Nitrogen is required for tissue building, carbon for fuel, and these two elements must be in proper relation. But what is the usual treatment in diabetes? Mistaking the *symptom* sugar for the disease, and with an erroneous view of the origin of the sugar, we reduce the carbohydrates of the diet to a minimum, thus disturbing the entire economy of the body. The patient, in an endeavor to get enough carbon, takes an excess of nitrogen; the kidneys are overtaxed in their effort to remove this excess, and finally become diseased. The body rapidly loses its power of assimilation of the grossly improper diet forced upon it; nutrition suffers, and finally the organism finds it easier to live upon its own substance than to build up new from the food. The body therefore wastes, in spite of the large amount of food ingested.

The symptom, sugar, may or may not be alleviated by such treatment. As all know, there are cases where even a rigid exclusion of all carbohydrate from the diet fails to reduce the sugar in the urine. Such cases may be likened to the toxic glycosurias of phloridzin,* etc. It is therefore evident that

* See article by the writer on "Renal Glycosuria," this Journal, Jan., 1897.

such a course may fail, even as regards the reduction of the sugar; but there is a serious result as well. In throwing the sustenance of the body upon the body proteids, the destruction of the latter is not only increased, but is so modified as to augment the formation of the poisonous aminobutyric acid and allied substances. No wonder, then, that the case assumes a more serious aspect, and that the presence of acetone, diacetic acid, etc., is to be regarded with alarm. Is not the unfavorable result to be expected? Is it not the physiological result of our treatment?

I recognize that many physicians have already determined upon a more liberal diet for diabetics, and I offer the above only in explanation of their more satisfactory results. Further, I would not wish to be considered an advocate of a full carbohydrate diet in diabetes. The fact is that the ordinary American dietary contains an excessive amount of carbohydrates, and there are but few patients who will not be benefited by a reduction in the starch and sugars consumed. I do suggest, however, that we arrange a diet containing a proper adjustment of carbohydrates, proteid and fat, and that we lend our efforts, not to remove sugar from the urine, but to improve the body metabolism.

PREVENTIVE TREATMENT OF ECLAMPSIA.—Prof. F. Ahlfeld, of Marburg, in pregnant women who present albuminuria, oedema, or other signs which lead one to fear the outbreak of eclampsia, has of late had systematic recourse to wet packs. Thus faulty secretory action of the kidneys is replaced by an increased activity of the other emunctories. The patient, wholly nude, is wrapped in a sheet which has been wrung out not too dry in tepid water. Over this a blanket is wrapped, the arms being kept inside, yet with a care not to impede respiration too much. A coverlet is then thrown over the patient, and she is left for about three hours thus, at the same time giving her plenty of carbonated beverages and milk. This measure is repeated twice a day. Out of thirty six patients, of which twenty-three were primiparæ, who were admitted with oedema and albuminuria more or less pronounced, where this treatment was employed, none had eclampsia. Besides, he had one patient who, after two successive miscarriages with albuminuric retinitis during her first two pregnancies, was able to go on to full term during the third with the help of these wet packs. Of course, other measures should not be neglected.—*La Semaine Médicale*, No. 5, 1901.

(This measure was taught in the medical department of Boston University years ago by Prof. Walter Wesselhoeft. "There is nothing new under the sun.")

EDITORIAL.

A PLEA FOR THE YOUNG PHYSICIAN.

How old are you? A woman is as old as she looks; a man as old as he feels. This is the usual standard for computing the age of individual members of society, and answers for all practical purposes until the telltale obituary or tombstone falsifies the reckoning. To the physician, as physician, his patient is as old as his arteries, and he treats him accordingly, while in estimating the age of his colleague he is prone to be governed too much by the date of birth or of graduation, and too little by the work done.

We have purposely jumbled together, in the above, ideas which apparently, as they stand, express incongruous points of view and different conceptions of age, but they are in reality all related by one common underlying thought.

We have, of course, nothing to do with the estimation of age in society, but wish only to offer a few suggestions as to the standard for the estimation of the professional age of a physician by his colleagues. We are led to do so by the frequent occurrence of depreciating criticisms of the work of younger physicians by their elders, based on a supposed superiority given by mere multitude of years. There is not always wisdom in the multitude of years. Our remarks may be taken as a plea for the young physician, and although he seems amply able to assert his own rights and position, and usually not at all loth to do so, we wish to see in how far these are justifiable.

That age is in no case a mere matter of years is shown by the varied standards referred to above. They all have underlying them the conscious or unconscious recognition of the fact that ability to act, to accomplish results, is the only criterion of healthy maturity of age of mind or body, and that the opposite condition is an evidence either of immaturity or of senescence. No physician, we believe, however much he may pride

himself upon the number of his years, either as recorded in the family Bible or the college register of graduations, will be willing to base his claims of superiority upon such empty data alone. The years that have rolled over his head must have been fruitful years, must have been employed in accomplishing results and fitting him for wider activities, if he desires to act as critic of the position and achievements of those younger than himself. The simple ripening of knowledge acquired long ago, without the attrition following the new acquisitions, is not enough to put a physician in a condition to pass final judgment upon the scientific problems daily presented to him in the advance of medicine.

Constant study, constant widening of his outlook over the ever-expanding field of medicine, can alone enable him to sympathize with and appreciate the position of the rising generation of physicians, and to correctly estimate their work. Judged by this standard, how comparatively small a number of old physicians are entitled even to pass judgment on the work of their younger colleagues, much less to disparage it. The criticism of work, influenced by a consideration of the age of the author alone, cannot be regarded as a criticism at all, but merely a prejudice, carrying no weight with it, and usually recoiling upon the head of the one uttering it.

But we would not wish to seem able to defend the young doctor by an appeal to the insufficiency of his critics only; more positive arguments must be brought forward in his defense. Compare the curricula of study according to which the older physicians acquired their knowledge of medicine with the curriculum of any reputable college of the present day. Both in the number and thoroughness of the branches presented there has been a most astonishing change. While we cannot imagine that the average young graduate has assimilated all that has been furnished him, we must recognize the fact that even the poorest student has been compelled to absorb more than was formerly offered. The wider range of didactic lectures, the generous laboratory facilities furnished, and the extended course of four years have rendered it almost impossible for any attendant at college to graduate without having obtained a fairly respectable amount of knowledge, greater in-

deed, at least in extent, than that possessed by the best graduate of old, after his short and restricted two years' course.

At the beginning, therefore, of their respective professional lives, the graduate of the present has had the advantage over the graduates of long ago. What was formerly only to be acquired by long and trying personal experience after graduation is now presented "cut and dried" to the undergraduate, who is, therefore, in reality, professionally older, when he is licensed to practice, than was his older colleague when his diploma conferred upon him the same right. Starting, then, with this advantage of an actual superior amount of knowledge, together with the advantage of the lengthened course of preparatory collegiate training, is it any wonder that the young physician of to-day is able, sooner than was the older one, to push to the front and to make his influence felt? To the qualified and ambitious young graduate of the present, one year is the equivalent of two, at least, in the good old times. Far be it from us in any way to disparage the results of the medical education of the past. There were giants in those days, but what they accomplished was done slowly, and had to be done largely by their own unaided efforts in all the various departments of medical science, while now, by the development of the specialties and the increase in the number of workers in them, our younger physicians are furnished with abundant material ready to hand with which to build, much more rapidly and less laboriously, as the spirit moves them. That the building will prove as substantial as have proved the laboriously constructed ones of the past we do not maintain, but only that it is unfair to judge of the possible merits of the work of any man by the number of years since his graduation, and that it is a sign of ignorance or of a willful ignoring of the changed conditions under which we are all working. It is not the number of years of natural or professional life which constitute the age or maturity of a physician, but the ability to do good work. By their fruits shall ye know them.

It would be foolish to attempt to deny the beneficial effects of years in tempering and restraining even too exuberant scientific activity, but that is at all times sufficiently provided for by the inexorable fact that we all must and do grow old; but rather a thousand times the restless enthusiasm of youth

than the self-satisfaction of premature senility, incurable even by sanmetto.

In looking over the history of medical progress we find that while very much has been done by old physicians, very much has also been accomplished by those who were comparatively young in years. Age does not, however, protect from folly, neither does youth render its possessors immune to wisdom. But while it is our duty in no case to belittle any man's work on account of his youngness, it is equally the duty of the young to remember that they have no monopoly of knowledge, and that wisdom will in all probability not die with them, as one would sometimes be led to fear from their seeming appropriation of the entire supply in sight. Modesty befits both old and young.

DR. HENRY M. SMITH.

THE sad news of the death of Dr. Henry M. Smith was received just as our April issue went to press, and was duly chronicled in our news pages. The notice thus given was entirely inadequate to express the admiration of ourselves and the profession in general for Dr. Smith's sterling character and strong individuality. Always a busy man, he like most busy men, always had time to do something more. During the last four years of his life he devoted his time entirely to his work as necrologist of the Institute, to the Pharmacopeia of the American Institute, and to the raising of the Hahnemann Monument. We can express ourselves of him in no better words than in those used by his colleague in the Monument work, Dr. J. H. McClelland: "He was one of the most self-sacrificing, hard-working members the Institute ever had,—a man of excellent judgment, of good intentions, and devoted to his craft. The Institute will never know the extent of his labors and self-sacrifice. His work on the monument alone should entitle him to the gratitude of every member of the homœopathic profession."

GLEANINGS.

THE TREATMENT OF TABETIC ATROPHY OF THE OPTIC NERVE.—The results obtained by Demichieri from the use of mercury in the treatment of tabes are in line with those of De Wecker, and lead him to the conclusion that the use of this drug is dangerous in such cases. Recently he has been employing nitrite of sodium with fairly encouraging results as far as the ocular symptoms are concerned. In all the cases which he reports there was an improvement in vision and an increase in the visual field. Five days per week he injected one gramme of a 6-per-cent. solution of the drug subcutaneously, and every other day he injected five or ten drops of the same solution beneath the conjunctiva.

In the one case, the subconjunctival injections alone were used, the result being as good as that which was obtained by the combined method. As a rule, he says, the patient notices an amelioration of his condition after five or six injections have been administered, the maximum result being obtained at about the end of two months' time.—Montevideo Demichieri, *La Clinique Ophthalmologique*.

William Spencer, M.D.

INJURY OF THE EYE FROM LIGHTNING.—This was the case of a telegraph operator who was struck while on duty. The following eye symptoms were present: Marked photophobia. Redness and some swelling of the lids. The conjunctivæ were considerably congested, and the congestion was pronounced around the corneal margin. The corneæ were bright and apparently normal, though in the anterior chamber of the left eye there was a slight exudate. In both eyes there was iritis, and in both lenses there were fine striations. It was difficult to make out the fundus. These changes in the eyes were accompanied with intense pain. There was a paracentral scotoma in both eyes. When a better view of the fundus could be obtained, small black specks were seen between the macular region and the optic nerve.

This was the case in both eyes.

The author attributes the changes in the eyes to two factors—first to the jar or concussion; and, in addition to this, to the action of the heat. Both of these factors would cause disturbances in the circulatory condition of the eye. The effect of the heat was seen in the œdema of the lids, and in the usual evidences of a burn; as, for instance, in singeing of the eyelashes, etc. In those parts of the eye free of blood-vessels, as, for instance, in the cornea and the lens, there was a clouding, usually transient in the cornea, but permanent in the lens. The changes found in the fundi were interesting, but he seems in doubt as to their origin.—Dr. Joseph Brixia, *Klinische Monatsblätter f. Augenheilkunde*.

William Spencer, M.D.

THE OPERATIVE TREATMENT OF PULSATING EXOPHTHALMOS.—Galowin gives us a comprehensive communication upon this subject. He first describes the clinical varieties of this affection, and then speaks of the treatment, first of ligation of the carotid and then of the orbital operations in these cases. He reports two cases where operative measures were resorted to, and in both he was successful. His conclusions are as follows: In every case the operative treatment of pulsating exophthalmos must be individualized according to the clinical form of the affection. In those cases where marked brain symptoms are present, as, for instance, vertigo, disturbing subjective noises, etc., one must by all means ligate the common carotid. In those cases where the clinical symptoms are confined to either the orbit alone or to the orbit and face together, it is better to perform an orbital operation. It is probable that in some cases one would get a good result by ligating the ophthalmic vein, making the incision under the eyebrows. The ligation of the ophthalmic vein, with a previous resection of the orbital wall, will be found generally useful in those cases where relapses have occurred or where ligation of the carotid has failed. In such cases, indeed, this operation should be given the preference to ligating the common carotid of the opposite side, since this latter is apt to excite too great disturbance in the cerebral circulation. Resection of the orbital wall must always be performed whenever the clinical picture of the pulsating exophthalmos suggests the possibility of an intraocular growth.—Dr. S. S. Galowin, *Zeitschrift f. Augenheilkunde*.

William Spencer, M.D.

THE PRESENT STATE OF ANTIDIPHTHERITIC SEROTHERAPY IN FRANCE.—Dr. Gillet, in a report to the Medico-Chirurgical Society of Paris, advises injection of serum as follows: in children of five weeks, 5 c.c.; 18 months to 2 years, 10 c.c. to 15 c.c.; after this age, 20 to 30 c.c. But these doses should not be exceeded (Sevestre). In certain cases massive doses may be necessary. A second and third injection may be given, if necessary, in twelve to twenty-four hours; it should not exceed 10 c.c. (Sevestre). From 40 to 50 c.c. will be the total amount required, though some cases may need 90 to 100 c.c.

Any case of real or suspected diphtheria should be injected at once, without waiting for a bacteriological examination. *Strike quickly, strike hard, but then wait.* This is a wholly harmless and very useful rule which is followed in the Paris hospitals; Dr. Moizard usually employs 2 c.c. In cases with associated croup one should inject at once in goodly doses. If the child be robust and the disease apparently benign, one may await the results of bacteriological examination; yet even then one should be on guard and ready to inject, if the disease show any inclination to become aggravated. *Rather too much of and too early with the serum than too little.*

In membranous croup one should inject early (and in good and strong doses), which may render tracheotomy unnecessary. Bacteriological examination will place the case somewhere in the following table:

A. Pure diphtheritic anginas: with the short bacillus.

: or, with the long bacillus.

Associated diphtheritic angina: with admixture of the streptococcus.

: with the staphylococcus.

: with other germs.

B. Non-diphtheritic anginas: due either to the streptococcus, staphylococcus, pneumococcus, the fusiform bacillus of Vincent or other germs.

In all pure or associated diphtheritic anginas the antitoxic serum is indicated, otherwise it should not be given. Yet where clinically diphtheria seems to be present, yet bacteriologically the results are negative, *the case should be treated as diphtheritic and serum injected*. The injections may be repeated if necessary, though some writers deny their efficacy. In general, if the general condition remain bad, the membranes persist or spread; if they extend into the larynx, and if the temperature remain high after twenty-four hours without being due to a complication, *then one should inject again*. It is well to know that an abuse of the serum, giving injection after injection, may prolong a febrile state (Sevestre).

Albuminuria is no complication, but a result of the disease as a rule. If the diphtheritic micro-organism be associated with other germs, the serum does not act as well. A subnormal temperature is a contra-indication, but if it be due to diphtheritic infection the antitoxin is certainly called for. Some French writers claim that antitoxine does not act favorably in tuberculosis (Variot).

The causes of failure are great virulence of the infection, secondary infections, especially streptococcic, broncho-pneumonias and various forms of septicæmia, asphyxia by obstruction of the smaller bronchi, croup, fibrinous bronchitis, lack of resistance, subnormal temperature, debility, former diseases, as measles, scarlatina and tuberculosis. Among these may be classed age; the younger the child the less the chances of success.—*Journal des Praticiens*, No. 12, 1901. (Five c.c. of Roux's serum correspond to 500 units of Behring's. Concetti, of Rome, injects 1000 units before examining bacteriologically, 1000 twenty-four hours later, if the case be found diphtheritic; on the third day 1000 if necessary, which is rarely the case. In more serious cases, or in croup, he injects 1500 to 2000 units immediately, then twelve hours later 1500 units, and twelve hours still later more or less, according to requirements. The total quantity varies between 2000, 3000, 4000, or even 10,000 units, according to the gravity of the disease, the age of the patient or the concentration of the serum. The general tendency of the profession is towards larger doses. In a case of membranous croup which I recently attended I gave 1500 units, and after six hours, as no improvement had set in, I injected 2000 units more. In a few hours amelioration commenced, and went on to an early recovery.)

Frank H. Pritchard, M.D.

ANOTHER CASE OF ILEUS WHICH WAS TREATED WITH ATROPINE.—Dr. A. Dietrich, in a case of volvulus in a man of twenty-five, who began to suffer from pain chiefly in the left iliac fossa, absence of stool and flatus, with painfulness to pressure in this region, diagnosed intestinal obstruction, probably due to a volvulus. After failure of opium, clysters and hot applications to the abdomen, he tried the atropine treatment, a measure which has been highly praised by a number of German physicians. A hypodermatic injection over the seat of the pain of $\frac{1}{80}$ gr. of atropine at 3 P.M. was repeated at 8 that evening, but in an increased dose of $\frac{1}{45}$ gr. That night he slept a little, though he both then and the following day was in pain. That afternoon he began to vomit feculent matter, his eyes were sunken, the pains so great that he would toss about in bed; pulse 100, dicrotic; temp., 37.6°. His abdomen in the left iliac region very painful to pressure, tympanitic, no dulness on percussion; tongue dry and very thickly coated. On examination by the rectum nothing to be

felt. Atropine $\frac{1}{2}$ gr. was injected under the skin over the left iliac region. Twenty minutes after he complained of palpitation and dryness of the throat; pulse 140. Twenty minutes later his pulse was 120, and the dryness of the throat had not increased; his pupils were somewhat dilated, but not wholly so; no increase of thirst nor vertigo. That night his pains were less, he had slept quite well, except that he had been disturbed by frequent discharge of flatus, and at 6 in the morning he had his first passage. It was moderate in quantity, dark brown, consistent but not hard, and without any pathologic admixture. His general condition decidedly better; pulse 90, slightly dirotic; temp., 36.5°; meteorism and sensitiveness to pressure were less. No disturbances of accommodation nor dryness of the throat. The following day he had slight drawing pains on moving about in bed and on pressure. The meteorism had almost disappeared; his tongue began to become moist; pulse 80. That afternoon he had another movement of the bowels. With increasing improvement, in four days he was wholly well.—*Münchener Medizinische Wochenschrift*, No. 8, 1901. (Quite a number of cases of intestinal obstruction cured by hypodermatic injection of *immense* doses of atropine have been reported in German journals. It seems certainly worthy of a trial, for these are desperate cases. I have often employed a hypodermatic injection of morphine and atropine in incarcerated hernias. It is a very helpful measure, which has usually helped me out in cases where it seemed that the rupture would require an operation.)

Frank H. Pritchard, M.D.

BELLADONNA IN ILEUS.—Dr. Moritz, of St. Petersburg, for the last thirty years, and that on the recommendation of older physicians, has been in the habit of using belladonna in conditions simulating intestinal obstruction. He administers extr. belladonnæ .015 every four to six hours; in six, eight to ten hours the first signs of poisoning, as dryness of the throat, are noticed, and very shortly before these appear the bowels are quite sure to move, while flatus is passed in considerable quantity without painful peristalsis or vomiting. This method of treatment he has found indicated in all cases of paresis of the intestine, appendicitis, peritonitis, mechanical occlusion of the intestines. At least from his experience in several hundred cases it has never done any harm. If an operation can be put off for a little while, this method of treatment may be the means of avoiding it, and at the worst improve the chances for a later operative interference.—*Münchener Medizinische Wochenschrift*, No. 10, 1901. (In a case of appendicitis, with a pint of pus walled up in one corner of the peritoneal cavity, it would seem better judgment to call in a conservative surgeon than to take the chances of its bursting into the free peritoneal cavity. Besides, there is such a thing as systemic infection from an appendiceal pus focus.)

Frank H. Pritchard, M.D.

TETANUS AFTER INJECTION OF DIPHTHERIA ANTITOXIN.—A correspondent of the French journal, *La Semaine Médicale*, reports on one of the possible dangers of antidiphtheritic serum. Recently, in North Italy, about twenty cases of tetanus amongst children have been observed after having been injected with an antidiphtheritic serum which was prepared at the Serotherapeutic Institute in Milan November 29, 1900. It was difficult to determine how the spores or virus of tetanus could have been mixed with the serum, and the numerous cases scattered over Lombardy could not all have been due to faulty

antiseptic precautions on the part of the attending physicians. Neither did the horse from which this serum was taken present any sign of the disease. Either the serum was infected from the horse's hair, which often contains the spores of tetanus, or the receptacle in which the blood was caught was infected. This latter is the view of the assistants at the institute. Unfortunately, on account of the smallness of the building, the same room was used for experiments with various microbes. An investigation is under way to determine the cause and to remedy it.—*Hospitalstidende*, No. 5, 1901.

Frank H. Pritchard, M.D.

AORTIC INSUFFICIENCY OF SYPHILITIC ORIGIN.—Dr. Chapman speaks highly of the effects of antisymphilitic treatment in a woman who was under his treatment for a heart somewhat enlarged, and with the auscultatory signs of aortic insufficiency. Suspecting it to be of luetic origin on account of various signs, amongst which were repeated abortions at the third month, she was given a course of mercury, followed by the iodide of potash. Eleven months later the aortic sounds were wholly normal, and thirteen months still later she gave birth to a healthy male child.—*Rivista Critica di Clinica Medica*, No. 4, 1901.

Frank H. Pritchard, M.D.

ON THE DIAGNOSIS OF TUBAL PREGNANCY.—Dr. Krapf, of Nuremberg, passing over the signs of advanced tubal pregnancy, which are easily made out, points out the difficulty of a diagnosis within the first three months, a time when an accurate knowledge of the patient's condition is quite important. The signs are: Firstly, of a more general nature, as pain in the abdomen or sacrum, moderate hæmorrhage from the uterus after the menses have been absent for one or two months. Secondly, sudden feeling of being ill, intense pain, fainting, and appearance of the phenomena of collapse.

In such a case either a simple tubal pregnancy or its consequences, tubal rupture or tubal abortion, are present. In the diagnosis a full history of the case is necessary—absence of cessation of the periods, the usual troubles of pregnancy, as vomiting, etc., and moderate hæmorrhage; it is very important to be on the watch for shreds in the bloody discharge, and a microscopical examination may eventually be required. Objectively, one may find the general and uncertain signs of pregnancy at the vulva, vagina and cervix, hyperæmia and secretion of the breasts, as well as the changes in the uterus and tubes. Behind and at the side of the uterus, which will be somewhat enlarged, is a tumor of the size of a walnut, and even larger, which will be very painful to pressure.

The diagnosis of a ruptured tubal pregnancy is easy. One meets with the very apparent signs of an internal hæmorrhage, generally dulness in the lower abdomen, more on one or the other side, and a history pointing towards pregnancy. In tubal abortion one never observes as acute symptoms as in rupture. Here the pains are labor-like, with external hæmorrhages and a retro-uterine hæmatocele may very frequently form, which is made out on internal examination, and may require puncturing.—*Münchener Medicinische Wochenschrift*, No. 10, 1901. (A flabby and relaxed uterus may, if associated with a number of indefinite and irregular symptoms during the first three months of pregnancy, give rise to a serious error. I know of such a case in a woman who a few years before had actually gone through what appeared to be a ruptured tubal pregnancy. It turned out that the isthmus was flaccid,

which allowed the uterus to surmount the cervix like a loose bag, toppling over to one side, with a little fœtus in it. It led a good diagnostician as well as myself into error, and it was only cleared up just before a laparotomy was about to be done for a supposed tubal pregnancy. On examination under ether the jug-like shape of the uterus could be made out, "sign of Hegar," with the flabby uterus tipped over to one side. I abstracted an article on these flabby uteri from an Italian journal a few years ago. It goes into this source of mistakes very thoroughly, and was published in the HAHNEMANNIAN MONTHLY.)

Frank H. Pritchard, M.D.

TREPANATION IN INTRACRANIAL COMPLICATIONS OF OTITIS MEDIA.—Dr. Taptas, of Constantinople, reports two cases of interest:

The first was that of a young woman affected with acute purulent otitis, with great headache. After seemingly sufficient drainage of the tympanum, irrigations, with a solution of formaline, were employed. The otitis appeared to be cured, but still the headache persisted. Two months later, though the middle ear appeared to be well and functionated normally, symptoms of mastoiditis set in. On opening the mastoid process it was found to be normal; but a large abscess was detected around the lateral sinus, which was freely laid open. The patient recovered.

The second observation was in a strong and robust man of forty, who, after what seemed to be a mild attack of grippe, and while convalescent, noticed a sero-sanguinolent discharge from his ear. Serious cerebral symptoms, as somnolence and complete aphasia, soon set in, and his temperature ran up to 39.5°. The ear appeared to be normal, and he complained of pain neither there nor in his head. The tympanic membrane seeming pressed outward, it was incised, and the cavity found full of pus. The patient died ten hours later of septicæmia. It is just in such cases, where the symptoms prevent one from obtaining an idea as to the state of the middle ear and its annexes, that he would advise an exploratory trepanation. Delay here may be fatal.—*La Grèce Médicale*, No. 2, 1901. (Some of these cases in young children may be mistaken for a meningitis.)

Frank H. Pritchard, M.D.

SOME OF THE COMPLICATIONS OF APPENDICITIS.—Prof. Dieulafoy, of Paris, in a paper recently read before the Academy of Medicine, calls attention to several interesting cases where he has observed vomiting of blood during an attack of appendicitis. This hæmatemesis, due to ulceration of the gastric mucous membrane, is a serious symptom; it has been also noted in incarcerated hernias. Appendicitis is by no means a purely local disease; not only is perforative peritonitis to be feared, but also an infection of the whole general system. A goodly number of cases of appendicitis associated with or without peritonitis have been published where an operation was done too late, as a general infection has followed from the local pus-collection about the appendix. After an apparently severe attack the appendicitis may appear to become quiet, but such cases are not to be trusted, for it may be only apparent. Then it has been observed that terrible complications may follow: purulent infection of the liver or pleura, gangrene of the lungs, grave icterus, albuminuria, oliguria, terrible vomiting of blood, etc. If in the future we come to look upon appendicitis not only as a local affection with threatening perforative perito-

nitis, but also as a disease which may be accompanied, at times, by insidious development of terrifying complications, as early as possible radical treatment of the primary focus will be permitted.

Lucas Championiere in the discussion asserted that during the last few years he had operated on a strikingly great number of abscesses of the iliac fossa—nineteen, in comparison with thirty-four cases during the past seventeen years. These he attributed to our recent epidemics of influenza and to a greater consumption of meat by the people, which led to a greater localization of disease in the appendix. In those countries where meat enters more into the dietary a larger number of cases of appendicitis are noticed. In Philadelphia he cites Keen to the effect that one-third of the population is said to be affected. The lessening use of purgatives is also a factor of importance. Opium he mentions only to condemn; purgatives are of signal service *in the beginning*. Some writers even advise them in perforation of the intestine.

In many cases, by the use of purgatives, one may prevent appendicitis. (I have found saline laxatives of decided value. In cases where a sort of appendiceal catarrh, with pain and uneasiness in the region of the cæcum, associated with constipation, led me to fear that eventually infection might follow.) He also mentions a chronic form of the disease, with digestive disturbances, but which also requires an operation. The prevention of appendicitis is only possible by a careful hygiene of nutrition and strict antisepsis of the intestines. Here purgatives are of the greatest importance. Other members confirmed his views, and one, Labbé, thought the disease to be one of the localizations of the grippe.—*Münchener Medicinische Wochenschrift*, No. 10, 1901. (In some, hyoscyamine or coniine are useful to control the symptom, pain.)

Frank H. Pritchard, M.D.

A CASE OF MELANODERMIA FROM BODY-LICE, WITH CACHEXIA AND PIGMENTATION OF THE BUCCAL MUCOUS MEMBRANE.—Dr. P. Chatin, admitting that those persons who are afflicted with body-lice may become covered with very extensive areas of cutaneous pigmentation, and at the same time being often in such a miserable and weakened state as to resemble a patient with Addison's disease, calls attention to the possibility of the buccal mucous membrane also being affected with similar patches of pigmentation. Such a patient might bother one in making a diagnosis. These examples are, however, rare. He recently observed a chiffonier of 70 years who entered the hospital literally covered with enormous pediculi corporis. He was extremely weak and emaciated; sleep was almost impossible on account of the itching. This state had existed for about two months, since when the color of his skin had changed. There was intense and uniform melanoderma, with its maximum wherever the clothes rubbed most, as the upper parts of the back and chest, the roots of the limbs and about the waist. On the contrary, it was not exaggerated around the nipples, on the penis and scrotum. On the internal surfaces of the cheeks there were numerous slate-colored spots of four to five millimetres diameter. Besides the asthenia, the gastro-intestinal disturbances, some vague lumbar and epigastric pains, the cough and oppression completed the resemblance to the clinical picture of Addison's disease. Only the absence of pigmentation *about the nipples and genitals* made him doubt without being able absolutely to reject Addison's disease. The further course of the disease righted matters. In three months the whole picture had

changed. His strength returned, the pigmentation cleared up day by day, while the spots in his mouth wholly disappeared.—*La Semaine Médicale*, No. 10, 1901.—(This "maladie bronzée" may be confused with a number of diseased conditions. The pigmentation produced by silver and arsenic are worthy of being kept in mind. Osler, Goodno and others, and particularly Rolleston in Clifford Albutt's *System of Medicine*, give an exhaustive discussion of the difficulties of diagnosis. I have recently read of cases of Addison's disease greatly improving under the internal use of extract of suprarenal capsule.)

Frank H. Pritchard, M.D.

NEUTRALIZATION OF TOXINES BY THE DIGESTIVE FLUIDS.—A number of investigators have demonstrated that most of the toxins and antitoxins are inactive when introduced into the stomach or rectum, and that they do not pass through the alimentary tract unchanged, since no part of them is discoverable in the urine or stools after the experiment.

Emulsions of the stomach, as also of the small and large intestines of rabbits and guinea pigs, carefully filtered, as a rule neutralize the diphtheritic toxin if mixed with it in various proportions. The emulsion of the small intestines is the most active in this respect, owing to the activity of the pancreatic juice. This secretion neutralizes the diphtheritic toxin when mixed in the proportion of 1 to 10,000. The gastric juice is less powerful. This difference does not depend upon the acidity or alkalinity. Watery extracts of the pancreas are just as effective.

In the case of the toxin of tetanus, the reverse condition is found. Here the gastric secretion, similar to the bile, has the most active neutralizing power. The bile, when mixed with pancreatic juice, is more active than when used alone.

The longer the various secretions remain mixed with the toxins before injection, the more marked becomes their neutralizing power. These secretions neutralize but do not render immune, for if they and the toxins are injected separately, the poisonous properties of the latter are not changed. In other words, the digestive fluids must act directly upon the toxins in order to be able to neutralize them.—*Centralblatt f. Bacteriologie*.

Frank H. Pritchard, M.D.

THE DANGERS OF THE INTERNAL USE OF THE PREPARATIONS OF ARSENIC.—Dr. Dupoux has made a study of the dangers of arsenic administered internally. All of its preparations are toxic, and expose one to danger if they be taken for too long a time. It is difficult to determine what is a dose devoid of danger, for intolerance is not due to the toxic properties so much as to its accumulative property and individual susceptibility. In general, it may be said that one may avoid poisonous effects by commencing with 1 or 2 mgms., and increasing according to tolerance up to 10 or 12 mgms., in twenty-four hours. It is well to interrupt treatment every three weeks, and, in general, to be on one's guard for signs of overdosing. These are by nature varied and numerous, and by their unobtrusiveness liable to escape one's notice.

The digestive tract at first usually shows signs of intolerance. There is stomatitis with ptialism, the gums are red, with a whitish margin, the tongue covered with a pasty coating. At the same time there may be garlicky odor to the breath. Gastric symptoms are anorexia, gastralgia, nausea and vomit-

ing. Diarrhœa may be the first sign noticed. The respiratory apparatus may present various disturbances, as coryza, with epistaxis, and at times pharyngitis and bronchitis. Besides, there is a queer feeling of burning and dryness in the œsophagus and pharynx, which has been noted by all writers.

Hæmorrhages have been noticed, though they are rare and rather seen during treatment with the cacodylates. There may be epistaxis, hæmoptysis, menorrhagia and metrorrhagia. An arsenical purpura has also been described. The disturbances of temperature due to arsenic have been but little studied; there may be a subnormal temperature, though notable elevations have been reported.

The disturbances of the nervous system are quite numerous. Pruritus is frequent; it may even go on to neuralgia, which often precedes the paralysis. Arsenical polyneuritis may be observed either as a paralytic or an ataxic form. The former greatly resembles alcoholic neuritis, so much so as to lead to mistakes in diagnosis. Trophic disturbances, both of the muscles and skin, are frequent.

Eye disturbances are often noticed, for conjunctivitis is one of the earliest signs of overdosing. At the same time amblyopia and amaurosis, though much rarer, may be seen. Disturbances of hearing are rarer.

The genital sphere may present functional changes; an anaphrodisia has been recorded, which is infrequent. In women menstrual disturbances are observed, and pregnancy may be interrupted by the prolonged use of large doses. Urinary disturbances are but little mentioned; small doses may produce polyuria, large ones anuria. There is exceptionally albuminuria.

Nutrition does not always gain from the use of the drug; an increase has only been noted after small doses, and that when arsenic is well borne. A prolonged use, on the contrary, invariably brings about emaciation. The skin lesions are characteristic: the first degree is a roseoliform or scarlatiniform erythema, which later becomes papular or urticarial. Rarer are the eruptions squamous. Besides these, an arsenical herpes zoster, purpura, etc., have been reported. Sweating is frequent. The characteristic arsenical melanoderma is an important phenomenon which is not wholly absolute, but is rather a mottling of the skin of an iron-gray color. Often the palms and soles will be affected with warts and hard wheals. The hair may fall out and the nails become thinned and deformed.—*Rivista Critica di Clinica Medica*, No. 47, Anno I.—(Dr. Markwald, *Deutsche Medicinische Wochenschrift*, No. 3, 1897, in a case of Hodgkin's disease in a man of fifty-six, who after treatment with Fowler's solution and Asiatic pills, without result, however, was afflicted with inflammation of the skin, furuncles of the face, and very painful and obstinate herpes zoster of the intercostal nerves. Hypodermatic injections of sodium arseniate, as suggested by v. Ziemssen, brought about a very decided reduction of the glandular enlargements, but at the same time there developed on all fingers a number of warts, which became very much inflamed. These disappeared after discontinuing the injections.)

(Homœopaths are not as much in fear of overdosing their patients, though it is a good idea to know what the effects are.)

Frank H. Pritchard, M.D.

CHLOROSIS WITH OPTIC NEURITIS WHICH SIMULATED A TUMOR OF THE BRAIN AND CAUSED DEATH.—Dr. A. Engelhardt relates the case of a young

girl of eighteen years, who for five years had at different times presented symptoms of anaemia, great fatigue, general weakness, headache, etc. Six months before entering the hospital her headaches had become intolerable, and her eyesight had so very rapidly decreased, indeed so quickly, that in a few weeks she had become almost blind. Ophthalmoscopic examination revealed an optic neuritis, with a choked disk, the arteries very narrow and the veins tortuous, with numerous white and bright spots, from an exudate about the papilla.

When admitted her general condition appeared to be good, though her cheeks and mucous membranes appeared very pale. There was a total absence of the sense of smell; otherwise the other organs functionated normally. General sensibility was not affected: there was a slight diminution of motility in the right arm, and she often complained of formication in her fingers. The patellar reflex, weak on the left side, was absent on the right. The blood contained only three millions of red corpuscles to the cubic millimetre, while the hæmoglobin was only 50 per cent. On account of these symptoms a diagnosis of brain tumor was thought justifiable.

Frank H. Pritchard, M.D.

HYPODERMATIC INJECTION OF GELATINE IN A CASE OF SERIOUS HÆMORRHAGE FROM THE STOMACH.—Dr. Frankenger was called to a woman of 57 who six years previously had had a severe hæmorrhage from the stomach, and who had suddenly commenced to vomit blood. Twenty-four hours afterwards she vomited a washbasinful of blood. While the gelatine was being prepared in solution she vomited blood twice again. At the time of injection she was cold, pulseless and completely collapsed. A solution was made consisting of 10 gms. of gelatine in 500 gms. of physiological salt solution, of which 200 gms. were injected, in two different places into the skin of the thighs, with Dieulafoy's syringe. The hæmorrhage ceased and did not recur. The patient rapidly recovered, when she was given the regular treatment for an ulcer of the stomach. At present she is wholly restored to health. The places of injection did not react and absorption took place rapidly.—*Munchener Medicinische Wochenschrift*, No. 6, 1901.

Frank H. Pritchard, M.D.

SECONDARY SUTURE OF RESECTED ULNAR NERVE, SEVENTEEN MONTHS' STANDING; IMMEDIATE RESTORATION OF FUNCTION.—Laplace (Phila.) reports a case where the ulnar nerve was divided at the elbow by an axe-cut, in a boy ten years of age. The usual ulnar atrophy followed. Seventeen months later the divided ends were exposed. The lower part was found imbedded in dense fibrous tissue. A neuroma had developed on the upper end, which was resected. The two extremities were approximated by steady traction, and held in position by ten sutures of fine silk passed through the neurilemma. The arm was dressed in the extended position. By the next morning the lad was able to move the little finger perfectly, and there was restoration of sensation. The writer holds that the restoration of function must have been immediate owing to perfect approximation, which allowed nerve-force to pass through.—*American Medicine*, April 6, 1901.

Gustave A. Van Lennep, M.D.

THE REPRESENTATION OF BILIARY CALCULI BY THE RÖNTGEN RAYS.—Beck (New York) calls attention to the use of the X-rays in locating biliary

calculi. The first successful skiagraphs of cholelithiasis were taken by him in October, 1899. Since then, perfected technique has made it possible to radiograph the common biliary calculi, "even if they are as small as the head of a pin," and also calculi of the hepatic ducts can be shown. A powerful tube which will bear a 15-inch spark for five minutes, and of medium hardness, is essential to success. A hard tube does not show enough contrast, and a soft one is not powerful enough to permeate the soft tissues. The operator's hand is a better indicator than any artificial skiometer. The position of the patient is important. He should lie on his abdomen, with three pillows underneath the clavicles, so as to protrude the gall-bladder forward, nearer to the plate. The tube should be as near the skin as possible. A five-minute exposure for thin persons and seven minutes for stout people give the best results, provided the tube works satisfactorily. The body of the patient should be turned slightly to the right, so that the rays penetrate the abdomen from the side, avoiding the thick, less transparent tissue of the liver. Only a small area shows distinctly on the plate, so great care must be taken to place the tube in the proper position. When the gall-bladder protrudes below the border of the liver, direct radiation is to be preferred. The writer prefers a Carbutt or Schleussner plate.—*New York Medical Journal*, March 2, 1901.

Gustave A. Van Lennepe, M.D.

IRREDUCIBLE DORSAL DISLOCATION OF THE PROXIMAL PHALANX OF THE INDEX FINGER.—Althorp (London) reports the case of a youth, sixteen years of age, who fell from a ladder, landing on the right hand, sustaining a dislocation of the proximal phalanx of the index finger. The luxation was backward of the phalanx, the metacarpal bone projecting into the palm; the finger was shortened and there was limited motion. Attempts at reduction failed. An incision revealed the glenoid ligament stretched over the head of the metacarpal bone, preventing reduction of the dislocation. Division of the constricting band was followed by immediate reduction. This case serves to illustrate the fact that not only in the thumb, but also in the fingers, reduction of a backward dislocation is prevented more by the glenoid ligament than any other structure.—*The Lancet*, March 9, 1901.

Gustave A. Van Lennepe, M.D.

PELVIC SARCOMA WITH CHYLOUS ASCITES.—Lee (London) reports a case of sarcoma of the pelvis in a woman fifty-eight years of age, with chylous ascites, cured by abdominal section. The growth filled the right pelvic and iliac fossæ, was covered by peritoneum, and had evidently developed between the layers of the broad ligament. The uterus was small and pushed to the left, together with a pedunculated mass the size of an orange. The rectum was free. Upon opening the abdomen seven pints of chylous fluid were evacuated. It had evidently been encysted between peritoneal adhesions. The cæcum and colon were displaced externally and posterior to the tumor, and the small intestines pushed upwards and matted together by firm adhesions. The tumor was beyond removal, so the abdomen was flushed with saline solution and a rubber tube drain introduced. The patient made a good recovery, and left the hospital in three weeks. Four and a half years have elapsed, and she has remained in good health. On palpation small masses can be felt in the right iliac region, and also in the right hypochondrium.

The uterus is small and atrophied. The mass in the broad ligament is still present, but much smaller. The author believes the growth to have started as a fibro-myoma of the broad ligament, as the tumor was present for ten years, and there was menorrhagia. Sarcomatous degeneration probably took place some six months before the operation, as the tumor then began to increase rapidly in size, with pelvic pain and considerable loss of flesh.

A cure cannot be claimed in this case, as the tumefactions are still present, and there is the possibility of their lighting up into renewed activity at any time. However, it is obvious that the operation in some way has inhibited the further development of the growth, and has certainly prolonged the life of the patient.—*The Lancet*, February 6, 1901.

Gustave A. Van Lennep, M.D.

EPITHELIOMA FOLLOWING THE STING OF AN INSECT.—Wolley (England) reports the following interesting case. A man, laborer, fifty-four years of age, consulted him for the relief of a tumor one inch in diameter, which had appeared on the external surface of the forearm five months before, following the sting of an insect described as a "green fly." The swelling was at first the size of a common nut, but increased as the patient bathed and poulticed the part in an effort to cause its absorption. It was confined exclusively to the skin, and was about one-sixteenth of an inch high, with the centre hollowed out and ulcerated. No involvement of the supracondylar or the axillary glands. The growth was removed, and under the microscope proved to be a squamous-celled epithelioma, with well-developed cell-nests. The question arises, was the growth due to the sting of the insect or the long continued irritation of the poultices that the patient applied to the part?—*The Lancet*, February 6, 1901.

Gustave A. Van Lennep, M.D.

A METHOD OF PERFORMING ANASTOMOSIS OF HOLLOW VISCERA BY A NEW INSTRUMENT.—O'Hara (Philadelphia), presents a new instrument for use in performing anastomosis of any of the hollow viscera. It "consists of two pairs of straight forceps, the jaws of which are very slender and two and a half inches long, for ordinary work; for special work they can be made longer. They are grooved down the centre of one blade; the opposite blade has a ridge similar to a pile clamp; both forceps are held together by means of an adaptation of the serre-fine."

The application of the forceps is as follows: The serre-fine is removed and one forceps is placed transversely across the bowel at the point selected to mark the upper border of the section, and locked; the other forceps is placed in the same manner at the lower margin of the resection. The tips of the forceps should be on an exact line with the mesenteric attachment. The resection is made in the usual way, cutting close to the forceps, and the latter approximated and locked by means of the serre-fine. A continuous or an interrupted suture is then applied, starting on one side at a point near the lock of the forceps, working towards the tips, across the mesenteric junction, then up the other side, from the tips to the lock of the instrument. The forceps are now unclamped and removed, and the opening in the gut closed by a stitch. Lateral anastomosis can be performed with the same ease.

The points of advantage claimed for this method are:

1. Reduction of the dangers of sepsis.
2. Rapidity.
3. Accuracy.
4. Wide range of application.
5. Simplicity.

With the same instrument there may be done a resection of the cæcum, of the pylorus, any portion of the small or large intestine. Anastomosis can also be performed on the large and small intestine, stomach, intestines of unequal calibre, and the various gall-bladder operations.—*Annals of Surgery*, February, 1901.

Gustave A. Van Lennep, M.D.

A CONTRIBUTION TO THE SURGERY OF MULTILOCULAR RENAL CYST.—Beck (New York) reports the following interesting case: Miss S., 55 years of age, developed within six months a hard, movable tumor, the size of a man's fist, in the left hypochondriac region, accompanied by digestive disturbances, low specific gravity and albumin in the urine, and hypertrophy of the left ventricle. Two sisters died from cystic degeneration of both kidneys. The left kidney was removed by the transperitoneal route, the abdomen being opened by a vertical incision alongside the outer margin of the rectus muscle. The right kidney appeared to be slightly enlarged and cystic at its lower end. The removed organ weighed nearly three pounds, and consisted mainly of hundreds of cysts filled with a thin white-yellowish fluid, which contained uric and hippuric acids, oxalate of lime and cystin. The patient reacted, but died eleven days after from uræmia. The autopsy showed the right kidney considerably increased in size and undergoing cystic degeneration.

True cystic degeneration is rare in adults. Its origin is in doubt. Kœnig, Fuerbringer, Rosenstein, Birch-Hirschfeld and Marchand say it is congenital. Ebstein and Virchow doubt it. Leichtenstein, Arnold and Landau claim a pyelopapillitis or nephropapillitis as a cause. Lejars assumes a peculiar proliferation of the epithelium of the uriniferous tubules, followed by colloid metamorphosis.

The author doubts the advisability of ever removing a cystic kidney, even when the other appears to be normal. For small cysts he advises puncture, followed by the injection of a drop of a saturated solution of iodoform in ether, while in larger ones the peripheral walls should be excised, or complete exsection, and suture of the renal wound. The transperitoneal route should be chosen in obscure cases or when the tumor is large, otherwise the lumbar route, because of its greater degree of safety.—*Annals of Surgery*, February, 1901.

Gustave A. Van Lennep, M.D.

REMOVAL OF POWDER-STAINS.—J. Neely Rhoades (Philadelphia), in a letter to the *American Medicine* for April 6, 1900, reports a case of powder-stains of the face successfully removed by the use of hydrogen peroxide, full strength. The writer does not fully explain the method of application, excepting that the solution was given to the patient to use on the face, and in two days the powder stains were entirely removed. As the usual treatment of these cases is very unsatisfactory, the preceding method is well worthy of further trial.

Gustave A. Van Lennep, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

CARCINOMA OF BASE OF BLADDER; MARKED RELIEF OF SYMPTOMS FROM MEDICINAL TREATMENT.—Dudley Wright, F.R.C.S., Eng., published some notes and remarks upon cases of genito-urinary disease in the *Homœopathic Review* for March, from which we have taken the following case: "It is not common," says the author of the paper, "for treatment to cause such a notable amelioration in the symptoms of carcinoma of the bladder as it appears to have done in this case."

The man was sixty-seven years of age. For two years he had suffered from irritability of the bladder, with thick and offensive urine. Had frequent calls to urinate—every quarter hour during the night and every half hour during the day. Had at times passed three teaspoonfuls of blood after urinating. Loss of weight, sixteen pounds in six months.

Examination showed: Enlarged glands in right groin. Hard nodule in right epididymis. Enlarged prostate. An irregular outlined, smooth mass or tumor of medium density, incorporated with wall of bladder, extending from left side of base of bladder just behind prostate, backward further than can be reached with the finger.

Diagnosis.—Carcinoma of base of bladder.

Treatment.—April 23, 1900, *Cantharis* 3x every three hours and *Triticum repens* tincture, five drops at night. Two weeks later it was observed that this treatment had improved the man's condition at first, but that he had relapsed; so *Ferrum picric.* 3x, two drops three times a day, was prescribed. Improvement began again, and was maintained for two months. Prescription continued during this time. July 2d, the patient had a sense of pressure above the pubes, much flatulence, and the urine contained much pus. *Lycopodium* 3x, two grains three times a day, and *Triticum*, five drops at night. This treatment being continued up to February, 1901, with on two occasions some *Cantharis* for strangury, the patient maintained his weight, and has been much improved. The growth is harder, possibly atrophic.

Dr. Wright thinks that in the chronic bladder troubles of the aged, few drugs are so generally useful as *Lycopodium*. This is especially the case in thin men who suffer from flatulent distention. It relieves the *bladder irritability*, which is often half the battle. *Triticum repens* tincture, given in small amount of water at night, is also useful.

Such results in this case of malignant disease should encourage us to hope for much benefit from our medicines in the less serious affections of the genito-urinary organs of old men.

O. S. Haines, M.D.

GOUTY CATARRH AND ITS TREATMENT.—In the *Monthly Homœopathic Review* for March may be found an article upon this subject from the pen of J. Galley Blackley, M.B., Lond. It is an article that grows on one on a second reading, and which shows that its author has devoted some time to the original investigation and study of that clinical entity which, for want of a better name, is known as the "gouty diathesis." Dr. Blackley sets himself the task of showing that there is a difference not only in degree, but also in kind, between gouty catarrhs and those which occur idiopathically.

The old family practitioner, who has been intimately acquainted with a gouty family during a generation, expects very early indications of the family failing in the children of gouty parents. Such a child will be predisposed from earliest infancy to eczema or impetigo. Later, he is especially prone to the various forms of respiratory catarrh, either in the shape of colds, coryza, bronchitis or amygdalitis.

The young men of such a family, after sexual intercourse, may suffer from blenorrhagia, with herpes of the glans or prepuce. This blenorrhœa may even be easily complicated with cystitis and epididymitis. At about the twenty-fifth year we may look for eczema affecting the fingers. And from this time onward he rarely fails to suffer from some form of gouty dyspepsia. Then, too, such an unfortunate is apt to contract from slight exposure catarrh of the respiratory passages, which may become chronic. He may have asthmatic attacks, granular pharyngitis or quinsy. The appetite, however, is not usually impaired, and hepatic troubles appear more or less dependent upon the abnormal appetite. He shows signs of irritability, impatience, impaired or diminished capacity for brain-work, and (horror of horrors!) he becomes bald.

Such then, in brief, is the history of a single generation of a gouty family. We must add, for the comfort of some chance reader, "some members of such a family may escape altogether."

After referring at length to the peculiar features of the catarrhs of the upper respiratory tract in such subjects, our author turns his attention to the chief points of difference between the *chronic bronchitis* as usually met with and the same thing occurring in an undoubtedly gouty subject. First we have the *history* of the patient, furnishing a record of gouty troubles, articular gout, attacks of eczema, asthma, red gravel or renal colic, with the voiding of uric acid calculi. In patients over sixty we must look for deafness with opacity of the membrane tympani, as this may furnish a clue to the nature of obscure bronchial ailments. We may find distortion of the finger- and toe-joints, or an irritable patch of skin on one or both shins slightly pigmented, or showing the scars of an old ulcer.

The urine will be dense and hyperacid, depositing uric acid crystals when an acid is added to it. The bronchial catarrh itself will likely be of the variety known as *catarrhus siccus*, differing materially from the humid variety in which the amount of the expectoration is enormous, and in which we may have bronchiectasis, night-sweats and clubbed finger-ends. The amount of expectoration will then be small, attacks of dyspnoea or genuine attacks of asthma may be expected, and perhaps emphysema may result.

Treatment.—In addition to the choice of a proper place of residence, the writer thinks that much may be achieved by a course of prophylactic medical treatment in such cases, and selects for this purpose either *Arsenic* or *Sulfur*, or *Kali hydriodicum*.

Treatment of Catarrhal Attacks Proper.—Arsenic, Kali hydriod., anti-monium-tartaricum and Ipecac are the remedies most to be relied upon.

Arsenicum.—Paroxysmal dyspnœa with scanty expectoration. Genuine asthma, dyspnœa with wheezing. Strangling cough from tickling in bronchi. Wheezing spasmodic cough and scanty expectoration of viscid, transparent, frothy mucus.

Ipecac.—May be given at the outset when the cough is strangling from bronchial tickling, and if dyspnœa is marked and accompanied by wheezing, but if the attack is prolonged Arsenic will follow nicely.

The author does not object to the alternation of Arsenic and Ipecac in such cases. Those of us who approve of the alternation of our remedies in practice may at least justify ourselves by the plea that "it's English, you know," for it truly seems to be, if one may judge from their many and otherwise most excellent clinical reports.

Kali hydriod.—May be given for dyspnœa accompanied by a copious expectoration and coryza. The author thinks best of this latter remedy and of the arsenicum.

Quebracho.—This remedy in the tincture, ten drops in water, will, if begun early, abort an acute asthmatic attack, or at least greatly mitigate its severity.

O. S. Haines, M.D.

ONOSMODIUM VIRGINIANUM IN HEADACHE FROM EYE-STRAIN.—Among the "Communications" in the *New England Medical Gazette* for last month was an excellent paper by Norton, of New York—one which should interest the "eye men" especially. The author of this paper thinks that while the permanent cure of headaches due to eye-strain requires the correction of refractive and muscular errors, yet the use of the *homœopathic* remedy is a most essential feature in a prompt relief of the annoying symptoms. Now, the peculiar excellence of Dr. Norton's article lies in the fact that he tells us *when* the onosmodium may be prescribed for this class of patients with some certainty of success. In other words, he gives us the characteristic head and eye symptoms as well as the general indications upon which the choice of Onosmodium should depend. These we have thought worth while to repeat.

Characteristic subjective symptoms: Heaviness and dullness of the eyes. A feeling as though he had lost much sleep. Pain in the left side of the head and over the left eye. Dull, heavy pain in the occiput, pressing upward, with a dizzy sensation. Soreness in the eyeballs. Tense, drawn, tired feeling in the ocular muscles. Accompanying these we will probably have great muscular prostration and tired feeling over the entire body.

This remedy having been pretty well proven, we would like to add to the symptoms given by Dr. Norton the following: Extreme drowsiness of mind and confusion of thought. Dullness of intelligence. Dazed feeling of the mind. Complete listlessness, as though it was impossible to think. Cannot concentrate one's thoughts nor remember what has been said. Pain in the neck, running back from the forehead. Dull aching in the neck. The side-walk seems too high, which causes him to step high. Insecurity in walking. These symptoms include a great many that are often mentioned to us by patients suffering from headaches of the kind we are considering, and the Onosmodium has certainly been helpful.

All the sensations of this remedy seem to be worse upon the left side of

the body; and while the characteristic headache of *onosmodium* is distinctly *left-sided*, still Dr. Norton has promptly relieved a right-sided headache, if accompanied by the sense of muscular weakness and that tired feeling which the popular mind once associated with "—'s Sarsaparilla."

Then, let us say, given a case in which there is the full, heavy pain over the left eye and left side of the head, extending down the occiput, together with a general feeling of muscular weakness, and we must think of *Onosmodium* as well as the more familiar *Cimicifuga*, differentiating them by the preponderance of the general prostration in the *Onosmodium* and by the general symptoms, which are different in the two remedies.

The pains of *Onosmodium* are all dull, heavy, sore or aching. They are not so sharp and cutting, consequently Dr. Norton remarks: "I never think of it in the inflammatory troubles of the eye."

Ruta Graveolens.—This remedy is also offered as one that must be of great value, in asthenopic cases, when the patient complains of a sense of heat and burning and aching in and over the eyes, with a blurring of vision. The letters seem to run together in reading. Thus it is apparent that the *Ruta* patient complains of the eyes themselves, and has few characteristic headaches, nor the prostration of the *onosmodium*. *Ruta* must be of more service in accommodative asthenopia due to weakness of the ciliary muscle.

Natrium muriaticum seems to suit asthenopia due to weakness of the internal recti muscles.

Senega is a remedy that has been of marked service in cases of paralysis of the superior and inferior recti muscles. After awhile, when more is known of the general action of the *Onosmodium*, it will probably take its place alongside of such remedies as the *Helonias dioica* in the treatment of affections of the generative organs of woman.

O. S. Haines, M.D.

TARAXACUM.—The tincture of this remedy, in the hands of Dr. Jousset, has given very prompt results in some cases of *hysterical tympanitis*. He used it in some very grave cases, and in cases where nothing else but puncture seemed to offer any hope.

Fraxinus Americana.—It is a pity that we have not more complete provings of this remedy, because the white ash bark has long been considered an active medicine by the common people in certain localities, and it has been greatly praised by J. Compton Burnett as a true organ remedy for the uterus. Dr. Burnett has told us that it reduces the backache and other discomforts dependent upon an enlarged and heavy uterus. Therefore it will be useful in the treatment of inoperable uterine tumors. More recently, Stevens, of Detroit, has prescribed the tincture with very gratifying results in cases of uterine displacement, particularly where congestion or sub-involution existed. (It should be of some value after operations upon the cervix and perineum, when the uterus still refuses to maintain its proper position, and fixation is refused.)

Hypericum.—This is a remedy not sufficiently understood even by homœopaths. We have no better remedy for the effects of *spinal concussion*. Dr. Talcott reports a case of progressive muscular atrophy due to a spinal injury. The patient was playing the great American game and took a "hot ball" in

the neck. Afterwards he suffered great pain. A noted specialist prophesied death within two years, but the disease was checked and great improvement followed the persistent use of *hypericum*. A tendency to *atrophy* of the injured parts makes a good indication for the remedy. It should always be thought of in *tetanus*. Then again it acts very well in some cases of *piles*. Dr. Ussher has found it far more efficacious than most remedies in the relief of the pain, bleeding and tenderness of inflamed hæmorrhoids. Not only here, but in the treatment of chaneroids and ulcers, it will relieve the excessive soreness and sensitiveness. It may be used both internally and locally. "It is the remedy par excellence for the prevention and relief of pain after surgical operations." (Staphisagria must not be overlooked here.)—W. A. Dewey, M.D., *N. A. Journal of Homœopathy*.

O. S. Haines, M.D.

ON SOME EXPERIMENTAL RESULTS OF TUBERCULINE BY DR. NEBEL DE MONTREUX.—The experiments have been conducted upon subjects affected with an early stage of tuberculosis.

Mental Symptoms.—Anguish, melancholia, continuous inclination to shed tears, nervous restlessness, susceptibility, indifference, loss of memory, aversion to work, and particularly to all intellectual excitation, dread of music.

Nervous System.—General debility, tired feeling in the morning, weakness in the legs after breakfast and after the least work; even talking would cause a rapid fatigue.

Pains.—Pain in the thighs, arms; pains lancinating in character; sensations like needles at the back, in the lungs, especially in the left, and at the apex. Pain at the margin of the liver, the spleen, ovaries, especially of the left, and in the region of the hip.

Paræsthesia.—Numbness of arms and feet, and especially at the head, in the part upon which the patient lies. Sense of contraction, beginning from the head, extending to the fingers. Contractions in the face, cramp-like pains at the stomach. Tight feeling in the chest and larynx.

Sleep and Dream.—Sleepy on the morning, persistent painful dreams. restless sleep, extreme weakness, desire to sleep after meals, insomnia, with profuse night-sweats. Morning sweats, and on rising. Chills when falling asleep; feet cold in bed; heat at night in bed.

Fever.—Heat in the head after meals, rapid change from cold to heat, sensation of heat on the mornings in the back. Cold feet in bed; after meals, heat producing sweats. Heat in the head, with nocturnal sweats. Heat general at night.

Sweat.—Profuse afternoons, at night, at the least exertion. Sweats preventing sleep; night-sweats, with heat in the head.

Skin.—Large brown patches on the forehead and the cheeks. Slight brownish coloration at the end of the fingers like that produced by nitrate of silver. Itching all over at night; cedematous swelling of the upper lip and the eyelids.

Bones and Articulations.—Weakness in the knees, pain in the articulation of the heel, of the hips, bruised sensation in both hands, worse from motion and effort, better by rest.

Head.—Vertigo, with headache; vertigo worse at night, after meals; vertigo compelling the patient to be seated to avoid falling. Noises in the head,

great lassitude, malaise. Burning heat in the head, slight morning headache, lasting until noon; frontal pain; headache, with visual disturbance. Headache, afternoon heat in the head, vertigo, headache lasting all day, with epistaxis, pain from nape to the forehead, burning and tearing in character. Pains, with longings to sleep, and with great noises in the ears.

Eyes.—Both upper and lower eyelids swollen, with headache; dark shadow before the eyes, with vertigo.

Ears.—Noises in. Frequent toothache, earache, headache at night, with violent nasal catarrh, which is profuse, trickling down the throat; epistaxis.

Taste of pus, of salt; tongue furred heavy. Aphthæ upon the tongue and the cheeks internally. Gums swollen as if full of pus, with burning pains; vesicled upon the lips as if from a burn.

Neck and Pharynx.—Pain, irritation at the neck, pain in the larynx, neck seems as if swollen, burning sensation at the pharynx, taste of blood arising from the throat.

Stomach.—Appetite poor. Pain in the stomach and in the abdomen, burning thirst, lips dry, with constipation and twitching, nausea; later diarrhœa, morning nausea, bad taste after meals, after drinking water; cramps of stomach. Vomiting at night. Swelling at the epigastric region. Pain in the abdomen. Clothing seems too tight. Pain around umbilicus, vomiting, diarrhœa.

Rectum.—Spasm of the rectum, pain, pressure, pruritus at the anal region.

Urinary Organs.—Urine scanty, frequent, desire to micturate frequently with the changes of weather.

Male Sexual Organs.—Pain in the testicles and the cord.

Female Sexual Organs.—Pain frequent at night and in the evening in the lower abdomen at the menstrual periods, pain in the pelvis, at the ovarian region. Weakness in the lower abdomen and at the back, painful menstruation. Burning sensation in the external genital organs, with profuse leucorrhœa. Menses prolonged or advanced.

Respiratory Organs.—Pain at the side, extending to the back, nocturnal pain in the chest, cough, irritation, hæmoptysis, pain at both sides of the chest, first in the right, then in the left. Expectoration in the morning, with violent cough, preventing sleep. Pain caused by laughing, by raising the arm. Stitching pain in the chest, with palpitation; pain between the shoulder-blades, extending to the neck, beginning from the left apex going to the axilla and to the arm. Stitching in the back, in the hip, worse from motions, pain at the splenic region, extending to the apex of the left lung. Burning pain in the back, with dry cough, profuse expectoration.

Heart.—Palpitation in the morning on rising, stitching pain in the lungs and the heart, with pressure in the lungs; palpitation with deep inspirations. Pain at the cardiac region. Palpitation at night, better when in sitting posture.

Generalities.—Marked emaciation, 6 lbs. in fourteen days, 20 lbs. in six weeks. In all experiments the 30th c. dilution was employed, one dose in globules every two to ten days, the most every six to eight days, prepared by Housemann de Saint-Gall. According to the author of this experiment the 100th c. often causes aggravation of the symptoms. (*Zeitschrift des Berl. Ver. homœop. Herte*, Dec., 1900.)—*L'Art Medical*, Jan., 1901.

John Arshagouni, M.D.

THE HAHNEMANNIAN MONTHLY.

JUNE, 1901.

THE MICROSCOPIC DIAGNOSIS OF ECTOPIC GESTATION, WITH ESPECIAL REFERENCE TO THE VILLI OF THE CHORION.

BY THEODORE J. GRAMM, M.D., PHILADELPHIA.

(Read before the Germantown Homœopathic Medical Society, October 15, 1900.)

THERE is no subject in abdominal surgery which has attracted so much attention as has ectopic gestation, and the splendid work of many distinguished medical men has yielded magnificent contributions to our knowledge. The time is distinctly within the memory of many of us when personal experience with a case of ectopic gestation was rightly regarded as meriting publication, for the recital was certain to receive marked attention and awaken well-deserved interest. The cases were then looked upon with interest not only as presenting a startling and dangerous perversion of a physiological process, but also because of their supposed rarity. Since medical men have, however, become accustomed, by frequent repetition, to hear of cases of ectopic gestation, and since the subject has been so frequently touched upon in considering the differential diagnosis of abdominal diseases, and now receives its merited attention in the didactic course, it has become quite apparent from the number of observed cases that, far from being a rare occurrence, ectopic gestation is surprisingly frequent. The literature of the subject, at the same time, has assumed gigantic proportions. In the consideration of ectopic gestation an interesting opportunity is presented for observing

medical progress. I feel confident that this point alone suggests a fruitful theme for an evening's entertainment. Let us, in passing, also notice to how great an extent abdominal surgery in general is indebted to gynæcologists.

Since my interest in this matter was awakened some ten years ago by the opportunity of observing a case of long-delayed delivery, due to the ectopic state of the pregnancy, rapidly followed by the eleven and a half month's ectopic pregnancy case* which I had occasion to operate through the kindness of Dr. A. M. Barnes, I have frequently remarked how numerous are the aspects which ectopic pregnancy presents for fruitful study. They are more numerous than the facets of a beautiful rose diamond, each one of which can excite our liveliest admiration as we intently regard its sparkling rays of reflected light. Since the opportunities for information concerning the general subject of ectopic pregnancy have multiplied, most of us are doubtless conversant with its clinical picture. We know more or less accurately that the patient has not recently given birth to a child, that she has missed her monthly period on one or two occasions, that she may be presenting symptoms simulating to a tantalizing extent an incomplete early abortion, that she has atypical metrostaxis, that she may have discharged some curious fleshy fragments in the uterine flux, that she may have had some obscure symptoms of syncope and more or less well-defined pain in the abdomen—and, gentlemen, some of us are perhaps but too sadly aware that we can recall a woman vaguely exhibiting some of these symptoms for a time, who, with awful suddenness, has been stricken down in the bloom of mature womanhood; and in a few hours, before we can rightly collect our diagnostic senses, she lies before us a lifeless thing, a victim of internal hæmorrhage, overwhelmed in her own life blood!

It is not the intention at this time to recite an interesting case, nor to consider the clinical diagnosis of ectopic gestation, neither to recount the processes involved in the early stages of this abnormal condition, nor to wrestle with the intricacies of the late, advanced cases—but it shall be my endeavor to touch upon the subject in a lighter way, while enter-

* *American Journal of Obstetrics*, vol. xxv., No. 2.

taining the hope that I may interest you for a few moments in considering how it is possible to obtain some aid in the diagnosis of ectopic gestation by means of the microscope, with especial reference to the presence or absence of chorionic villi. With no intention to apologize, I may say that to those of us who are actively employed with clinical microscopy I shall possibly not have the privilege of presenting anything new; but there are doubtless others who may not have happened to think of the subject from the present point of view, or who may not have followed the more recent applications of the microscope. I am led to hope that some profitable entertainment may be derived from this consideration when I remember the fixed attention which was, on some previous occasions, devoted to my attempt to elucidate two little points in connection with this practical way of looking at ectopic gestation.

The first point to be considered relates to the uterus—that organ of which the ancients were not certain but that there existed some valid evidence of its possessing life independent of the woman. Now we all know that as soon as the ovum is fertilized, the uterus, responding to that all-pervading influence which seems to permeate the entire maternal organism to its utmost confines, at once inaugurates certain changes within itself which are preparatory for the nine months' residence and maturation of the embryo. These changes there instituted consist in a transformation of the lining membrane of the uterus, improperly spoken of as mucous membrane, into the deciduæ or the caducous membranes. These changes consist in an enormous proliferation of the cells of the endometrium and in a great increase in vascularity, so that the membrane becomes much thicker. At first the glands also grow proportionately with the cellular portion of the membrane; but later they are not able to keep pace with this growth, and the cells are thus enabled to superimpose a stratum upon the glandular layer. Thus there is a cellular and a glandular layer formed. These processes, when completed, present the decidua as composed of a myxomatous reticulum containing large embryonal or decidual cells closely approximated but not compressing each other. It is difficult to see this reticulum with low powers of the microscope, because the cells occupy the meshes so thoroughly that only the

large decidual cells are seen. These cells have the size of about from five to fifteen times that of a red corpuscle, are granular, nucleated, protoplasmic bodies. Within this membranous structure are also found capillary blood-vessels and modified glands of the endometrium.

Let us bear constantly in mind the fact, particularly important for our present purpose, regardless of the exact locality of the fecundated ovum,—whether it be yet situated in the ovary, in the peritoneal cavity, in the channel of the tubo-ovarian ligament or peritoneal fold, within the fimbriated extremity or in any other portion of the Fallopian tube, or in its proper place in the cavity of the uterus,—that this decidual membrane forms. All available evidence favors that statement. The membrane may not be discoverable, it may elude our careful search in the uterine discharge, or it may have gained unnoticed exit, but it is very probable that it exists, or has existed, in every case of pregnancy. This is a fact which is essentially interesting for us at present.

Now, while the changes which eventuate in the formation of the decidua are progressing within the cavity of the uterus, the marvelous transformations in the ovum itself are advancing with wonderful rapidity. These changes have already begun while the ovum is pursuing its difficult and perilous journey amid the intricacies of the Fallopian tube. The difficulties in transit which the ovum may encounter within the tube are suggested by the accompanying photo-micrograph (Plate 1), which represents a cross-section of the ampulla of the Fallopian tube in as nearly normal a condition as it is, perhaps, possible to obtain one. When the ovum reaches the uterine cavity it finds the decidua awaiting its reception. The ovum has inaugurated or has passed through the various processes of segmentation and the formation of the ectoderm, the mesoderm, and the entoderm, and the other portions of embryonal development, which need not be mentioned now, since they relate to the embryo itself. However, two of the three layers of the vitelline membrane have disappeared, and the zona pellucida alone remains. To this the false amnion has applied itself, while the true amnion has been formed enfolding the embryo. The allantois has developed and has expanded between the true and the false amnion, so as to cover the entire ovular periphery, and now it

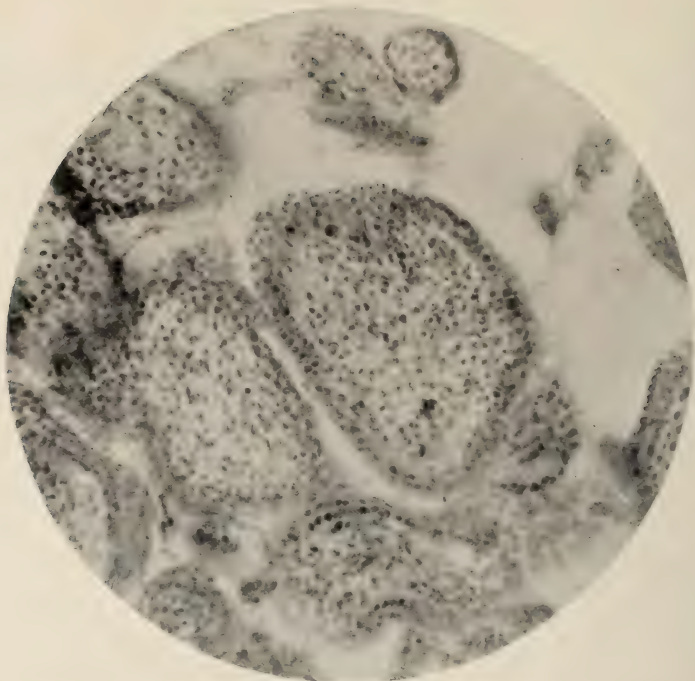
adds its substance to the two first-named membranes to form the chorion. Upon the surface of the chorion numerous fine villous processes have developed, and are seen upon the earliest ova which have been discovered. These membranes, to which this hasty reference has been made, constitute the fetal contributions to the placenta.

FIG. 1.

The Fallopian Tube, $\times 50$.

The villi of the chorion must now engage our attention. They are unique in structure and in appearance, and we must endeavor to obtain some conception of that appearance. (Plate 2.) It is fortunately also possible during a prolonged subsequent period to recognize a chorionic villus, in fact long after adjacent tissues have begun to lose many of their distinctive characteristics. The villi consist of loose embryonal connective tissue into which a small blood-vessel has been projected from the allantois, and they are surrounded by two layers of cells. It

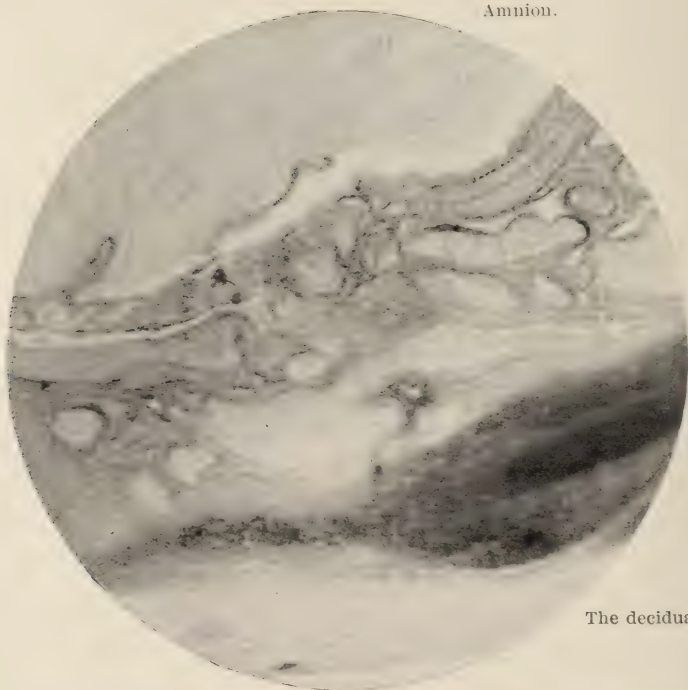
FIG. 2.



Villi of the Chorion, from a case of early incomplete abortion, $\times 200$.

FIG. 3.

Amnion.



The chorion and its villi.

Hæmorrhage separating the chorion from the decidua.

The decidua.

Membranes of Young Embryo showing amnion, chorion and decidua ($\times 75$), with blood-clot separating chorion from decidua.

is the function of the villi to establish a connection with the maternal organism, so that their contained vessels may derive the requisite nourishment from the maternal sinuses. They are

FIG. 4.

a

b

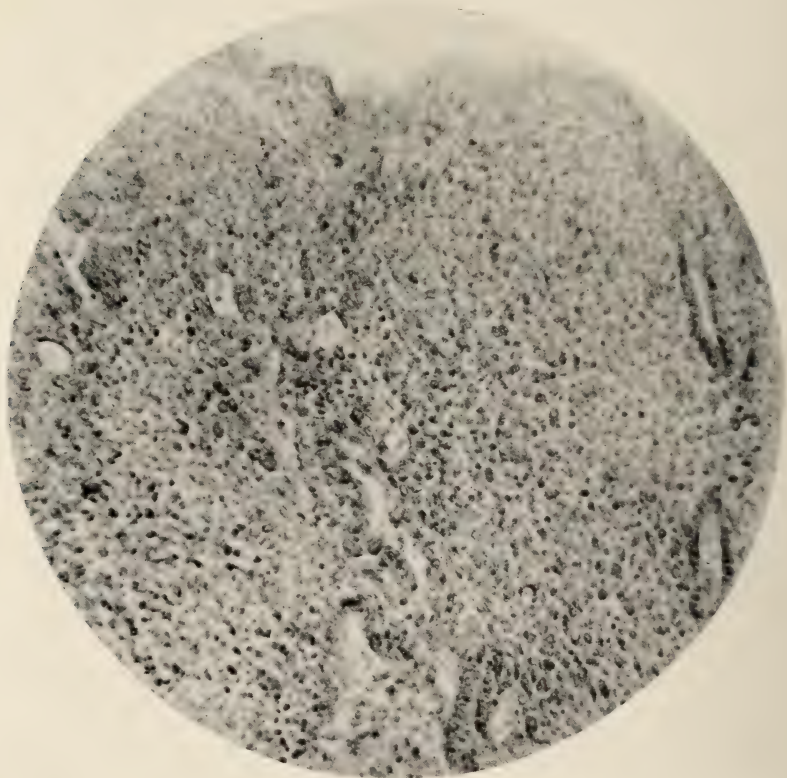
Normal Placenta, $\times 75$.

a. The amnion. b. Cavity of the amnion. c. The chorion. d. The decidua.

really the tendrils of the parasite. The connection formed between the embryo and the decidual membrane in the uterus, by means of these tendrils, is capable of being broken more or

less completely until the third month, when the placenta is fully formed; but after that time it can no longer be broken with such ease that no vestige of the presence of the villi of the chorion is discoverable. Even before that time, any attempted separation will leave sufficient evidence for careful microscopic demonstration. To recapitulate, the placenta is formed from decidual

FIG. 5.



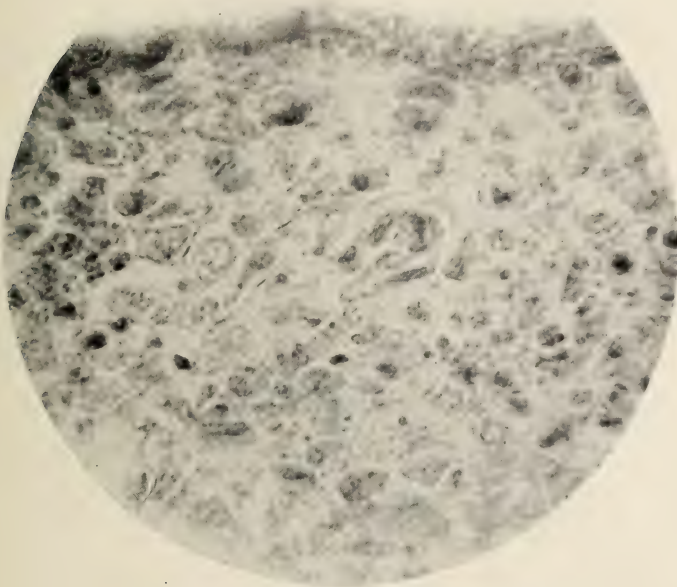
Uterine Decidua of Tubal Gestation, $\times 200$. Shows uninjured free surface, some utricular glands, and capillary vessels. The membrane contains no chorionic villi.

tissue, from the chorion with its characteristic villi projecting into the vascular sinuses, and from the amnion. (Plates 3 and 4.) The microscopic diagnosis of intra-uterine pregnancy will depend upon the recognition of these structures. In endeavoring to accomplish this, however, we encounter certain difficulties which are mostly dependent upon the stage of development to which the products of conception have attained; and these

difficulties will be much enhanced by the usual impediments which from ulterior motives are made intentionally to disturb the accurate demonstration of all sexual subjects.

If now, in a given case, it be possible to demonstrate microscopically the presence of a portion of the placenta, consisting of amnion, vascular sinuses, portions of the chorion, and fragments of the decidua, the diagnosis of intra-uterine pregnancy is assured—but then we have not assumed for ourselves a problem whose solution is so easy as that! We will, however, sup-

FIG. 6.

Uterine Decidua of Tubal Gestation, $\times 500$.

pose that the amnion is not present, for it will probably have been discharged simultaneously with the embryo. It has been pointed out above that prior to the third month it is possible to separate more or less completely that attachment between the chorionic villi and the decidua; but it is true that portions of the chorionic villi are apt to have formed so intimate an attachment with the decidual membrane as to make it unlikely that every vestige of their one time presence will have disappeared under the ordinary circumstances in which it may become our task to demonstrate their presence. It has also been stated that

FIG. 7.



Unruptured Tubal Gestation. Right Fallopian tube. Anterior view. Natural size. The fetal sac distends the Fallopian tube and protrudes from the greatly-dilated fimbriated extremity at the left, below. To the right is the ovary. Between the ovary and the protruding fetal sac is a hydatid of Morgagni.

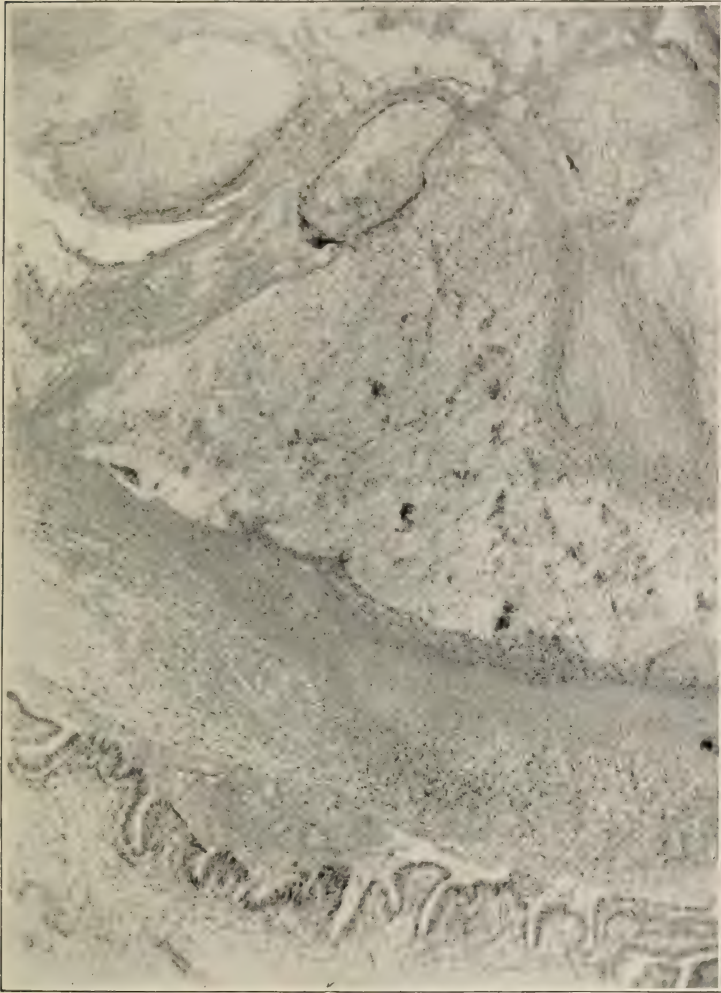
FIG. 8.



Tubal Gestation in the Right Fallopian Tube. Anterior view. Reduced one-half. Primary rupture has taken place into the broad ligament, which is distended with blood-clot and fetal membranes, at the left. The enlarged ovary is seen at the right.

the villi of the chorion retain for a protracted period sufficient of their characteristic semblance to permit their recognition.

FIG. 9.



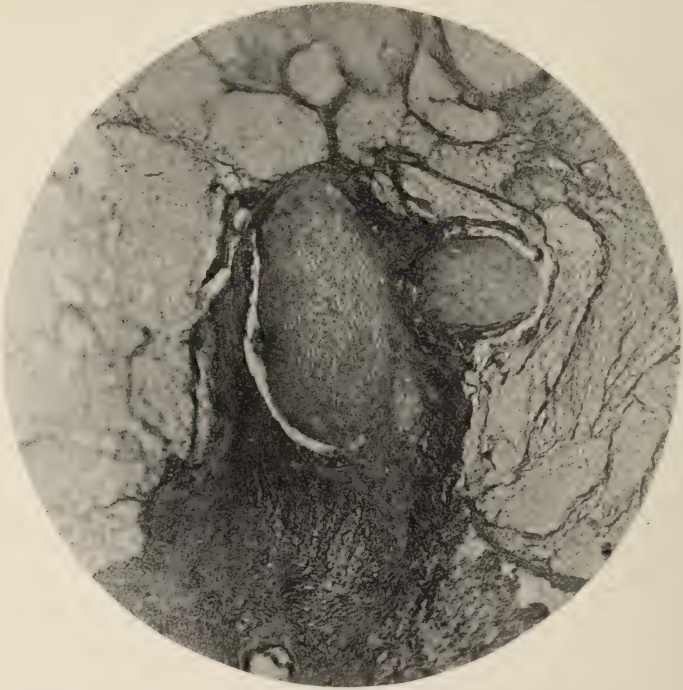
Tubal Gestation, $\times 75$. Section through the Fallopian tube still containing blood-clot and embryonic remains. Four chorionic villi are seen above. The inner surface of the tube is seen below.

For these reasons, and because of other microscopic evidence, it happens that after a long interval it may still be possible, in a given case, to affirm that the patient was recently pregnant. I

have had some interesting experiences in verifying this possibility in cases where the pregnancy was strenuously denied. The proof here consisted in recognizing chorionic villi attached to decidual tissue undergoing the usual retrogressive changes, imbedded in a very unpromising blood-clot.

We must next consider the question of the microscopic diagnosis when no chorionic villi are to be found in the membranous fragment obtained from the uterus, and when that membrane

FIG. 10.



Chorionic Villi and Embryonic Remains in a Blood-Clot, $\times 75$.

is so perfect in its structure as to warrant the belief that no chorionic villi have ever affected it; and yet here is the maternal contribution to the placenta. We have then to deal with the lining membrane of the uterus which has undergone some proliferative modifications, pathological or physiological in character. If this point were to be properly presented, especially with respect to differential diagnosis of tissue changes, it would lead us to consider the various so-called forms of endometritis—a subject too extensive for the present occasion.

It may, however, be said that, should the fragment under consideration be derived from a case of actual endometrial inflammation, the usual small-celled infiltration of the interstitial variety or the proliferated glands of the glandular form will sufficiently distinguish them. The other forms of endometrial change are not likely to cause confusion.

The decidua of ectopic gestation has a different and distinctive structure. The endometrial surface epithelium is flattened, rather cuboidal than cylindrical, and rests upon the layer composed mainly of cells, as described by Friedlander. Beneath this is the cellular layer containing the modified uterine glands. The decidual cells themselves, derived from the connective-tissue cells of the endometrium, are large, closely approximated, irregular in size, sometimes polynucleated, the protoplasm finely granular. (Plates 5 and 6.)

Now in an actual examination of a fragment from an ectopic pregnancy this microscopic picture will be seen, and if the specimen be complete the uninjured surface of cuboidal cells will appear; if the fragment be imperfect this layer will be absent, but still the large decidual cells will be manifest, enclosing imperfect endometrial glands, in addition to blood-vessels and lymphatics. There will be no trace of chorionic villi discoverable, for the reason that while the uterus has been induced to begin the preparation necessary for the reception of the ovum, the expected visitor has not arrived; consequently the chorion has not developed, there being a foetal derivative, and hence there are no chorionic villi. When a structure corresponding to this description is recognized in the fragments discharged from the uterus, or which has been removed from that organ by curettage for diagnostic purposes, we may say with certainty that we have to deal with decidual tissue, and we may also say that the woman is, or has been, pregnant somewhere; and, from our knowledge of the pathology of ectopic gestation, that there exists tubal pregnancy. The subjective and objective symptoms which the patient presents, especially those capable of being elicited by vaginal examination, will obtain material confirmation in establishing the diagnosis. The time during which the decidua of ectopic gestation may be obtained from the uterus seems to be subject to great variations. In my case in which the ectopic pregnancy was

terminated by abdominal section during the twelfth month, there had been but comparatively little uterine hæmorrhage until the time of operation, and the decidua was discharged in fragments from within a few days to as late as somewhat after the fifteenth day post-operationem, as nearly as I can remember now. It is probably exceptional to observe so late a retention of the decidua. The rule doubtless is that the decidua is discharged in the uterine hæmorrhage which accompanies primary rupture of the tube, or continues for a variable time subsequent to that occurrence, provided the patient survive the accident.

On the other hand I may say, as showing the other extreme of possibilities, that sometimes the membrane is discharged very early in the uterine hæmorrhage, and it is this discovery of the fleshy fragments which has sometimes, with such disastrous results, suggested the incorrect diagnosis of early uterine abortion. This early discharge happened in the case of unruptured tubal pregnancy which is represented in Plate 7. In this instance a curettage for diagnostic purposes was made, but the walls of the uterine cavity were found to be surprisingly smooth, and it was not possible to obtain even sufficient tissue for microscopic examination. I was therefore compelled to base the diagnosis upon the existence of a rapidly growing tumor, during the period of observation, situated beside the enlarged uterus, in addition to the location and shape of the suspicious mass.

The second main point to which I desire to call attention is the aid which the microscope may give in diagnosis from conditions found within the abdominal cavity. When an abdominal section has been made for suspected ectopic pregnancy, and the cavity of the abdomen lies open and exposed to the senses of sight and of touch, it is not always possible at once to make a certain diagnosis. The conditions encountered are quite variable. Sometimes we meet such a beautiful and easily recognizable specimen as is shown in the accompanying plate. But even these specimens only a few years ago were the subject of controversy. Such a condition was called a hæmatosalpinx, and there is no doubt but that, in accordance with the definition of that word, there exists a collection of blood within the Fallopian tube. It is the merit of Lawson Tait to have materially contributed to our correct information of these conditions. But

besides these specimens, which show the pregnant tube just on the point of rupturing, and in addition to this other case (Plate 8) in which primary rupture has taken place, but wherein the hæmorrhage is still circumscribed and retained within the folds of the ligamentum latum, we sometimes encounter cases which present many more difficulties for microscopic diagnosis. I refer to those instances in which, on opening the abdomen, the peritoneal cavity is found to be filled with large masses of fluid and coagulated blood. On careful examination it may be discoverable that the blood flowed from the patulous, greatly dilated fimbriated extremity of the Fallopian tube, or came from a rent in the tube wall—that is to say there exists either a tubal abortion, as Werth has aptly called it, or there is a tubal pregnancy which has ruptured through the free surface of the Fallopian tube. These cases have been called pelvic hæmatocele, and there is here also no question, according to the significance of the term, of there existing a collection of blood in the pelvic cavity; but the diagnosis is inaccurate. Let us as quickly as possible accept the idea that the chances are in favor of this also being a tubal pregnancy, and not be mislead by applying an inaccurate term which permits us, with a certain amount of justification, to pursue a vacillating and dangerous course of treatment.

Now, when an impregnated ovum fails to consummate its perilous passage through the Fallopian tube by reason of causes which are not as yet clear, the same changes begin in it as occur were it not ectopic. The developmental processes rapidly advance, and soon—frightfully soon, I have thought—the embryo has put forth these dangerous filamentous projections, the villi of the chorion, and they perforate the contiguous tissues of the tube in their endeavor to establish the parasitic existence of the embryo. The plicæ of the tube and the tube wall are not nearly so resistant nor so thick as is the wall of the uterus, and in about twelve weeks the life of the woman is in jeopardy, for the villi have so thinned the tube that rupture is imminent.

If the progress of the case be interrupted before rupture, or even after rupture into the broad ligament, the microscopic diagnostic problem is more simplified than after that time when free hæmorrhage has occurred into the abdominal cavity. It can readily be understood that this free flow of blood is very

apt to wash away from their original location in the tube many of the evidences of the actual conditions, that is of the pregnancy. Thus the embryo, to whatever stage of development it may have had time to advance, has not seldom vanished from view. Some of its membranes also have disappeared, and have left no trace. Fortunately, however, these little villi of the chorion do not so completely disappear but that traces of them can be found. It is, of course, understood that we are now not considering other available and confirmatory evidences. In that portion of the tube where the chorion frondosum has formed, namely, where there has been an attempt to develop the placenta, the villi may be found still within the tube near the walls, or they may be separated from the plicæ of the tube by intervening masses of blood. (Plate 9.)

Within the tube is not the only location where the villi are to be sought. After primary rupture into the broad ligament, the blood masses situated within the broad ligament should be examined, and these may reveal the evidence desired. In addition, any blood-clots in the immediate vicinity of the tube, or those which in any way appear to adhere with more than ordinary tenacity to any portion of the tube, should be carefully preserved and prepared for microscopic examination. From what has just been stated, it may readily be inferred that in some instances the greatest perseverance is necessary before it is possible to find the evidences of pregnancy of which we have been speaking. I have on several occasions carefully prepared a number of such specimens, which on section proved to be but blood-clots. Diligent search, however, will usually be rewarded. The appearance exhibited in a case which offered some such difficulty is presented in Plate 10.

Lest an erroneous inference be drawn from the foregoing, I would say just a word in conclusion. It is not the intention to leave the impression that the villi of the chorion are the only microscopic evidences obtainable of the presence of pregnancy. Much more might be said about the cells of the decidua within the uterus, and about that appearance of decidual changes which some believe to have observed within the tube. I have purposely avoided distinctly technical considerations, and have mentioned no more than every practitioner can easily apply who in any way makes use of the microscope in clinical medicine.

OBSTETRICAL INTERFERENCE.*

BY EDWIN H. WOLCOTT, M.D., ROCHESTER, N. Y.

Obstetrician to the Rochester Homœopathic Hospital.

CASE I.—*Induced premature labor at eight months for uræmic convulsions.* Mrs. Y.; age 20; primipara; nativity, Canada; occupation, housewife. Diseases during childhood: measles, scarlet fever and whooping-cough. First menstruation occurred at 14 years of age. Quickening was noticed June 1, 1900. She was admitted to the Rochester Homœopathic Hospital at 2.30 A.M., September 16th, in a violent convulsion. Her husband stated that she had partaken quite freely the evening before, upon retiring, of onions and beer. Her condition was so serious that it was decided to induce labor at once. She was not in labor and there was no dilatation of the cervix, but the child was alive and quite vigorous. Her preparation consisted of a hurried bath, douche and enema. Gels. 2x was administered often for its well-known effect upon the cervix, and the patient placed under the influence of chloroform at 3.30. A specimen of urine was secured by catheter and immediately examined, with the following result: Sp. gr. 1010; albumin abundant; urea .007 per cent., and tube casts. Her urine had been sent to her physician several times during the last two months, but she had not been advised of the result of the examinations, so I am unable to state what was found regarding it previous to her admission.

I then proceeded to dilate the cervix with my thumb and finger. In half or three-quarters of an hour it was sufficiently dilated to admit the blades of my forceps, and the head was grasped at the superior strait. I did not note the position at this time, but afterwards discovered that the occiput was posterior and the face at the symphysis pubis. Steady and powerful traction was made on the head in order to deliver the fœtus in this undesirable position and with a cervix only partially di-

* Read before the Homœopathic Medical Society of Western New York at the annual meeting held in Rochester, April 12, 1901.

lated. The forceps, however, were in excellent relation to the head, so that they did not slip or cause any permanent injury. In about an hour the cervix yielded with a tear in the anterior lip of about an inch in depth. The second and third stages were then soon over, the child being born at 5.30. After ten or fifteen minutes it was resuscitated, but was too weak to nurse for five days, being fed meanwhile with milk from a medicine dropper. Its weight at this time was five pounds. The mother remained in a convulsive state most of the time for the next twelve hours, when she regained perfect consciousness, and had no further trouble. While still in convulsions the chloroform was continued in a mild degree, with frequent doses of bell. 2x, for its curative effect. In addition to this treatment her skin was kept moist with steam baths; foxglove poultices were applied over the kidneys every three hours, to increase the secretion of urine; and salt solution enemata were administered frequently for rectal absorption.

An examination of the urine on the 18th showed sp. gr. 1011; albumin less, and urea .012 per cent.; and on the 21st, sp. gr. 1016; albumin small amount, and urea .015 per cent.

She then made an uninterrupted recovery, being able to sit up the ninth day, and was discharged from the hospital September 30th, or on the fourteenth day of her illness.

Although the baby's vitality had been severely tried, not only by the mother's condition but by the difficult and entirely artificial birth, it gradually gained in strength, and has nursed nicely since the fifth day. During the first six days after birth it received five drops of brandy every two hours. Arnica oil was applied to its head to relieve traumatism, while, owing to its jaundiced condition, bry., ars. and pod. were given from time to time for three weeks or more. The baby is now (April 12th) apparently well, gaining gradually in strength and weight, and although it had been *in utero* only eight months, it still lives, and bids fair to become strong and healthy. December 12 the baby weighed twelve pounds.

The mother was requested to return for examination in three months, but she was so proud of her recovery that she came to my office, and in excellent condition, when her baby was only a month old. On December 12 a vaginal examination showed considerable laceration of the left side of the cervix, but the urine was entirely free from albumin.

CASE II.—*Induced premature labor at eight months for dead fœtus.* Mrs. H., age 40; multipara; entered the hospital October 10th, being eight months advanced in gestation. Upon careful examination and inquiry it was decided that her fœtus had been dead six weeks. Quickening had correspondingly ceased, the breasts were collapsed, and there was a dull, heavy weight in the pelvis. Her size had not increased during this time, but rather diminished. She was in perfect health otherwise, but it was thought best, on account of sepsis, to interfere, and not wait for natural expulsion. The patient was anesthetized, and the cervix forcibly dilated,—only enough to introduce a strip of iodoform gauze two or three inches in depth. The object of inserting gauze was its less liability of rupturing the amnion, which was to be avoided if possible. The vagina was then loosely packed with sterile gauze, to hold the iodoform gauze in place, and for its reflex irritating effect upon the uterus, and the patient returned to her bed. In about forty hours normal labor pains were noted, and the gauze was expelled from the uterus. The pains continued with somewhat increasing severity for twenty-four hours, when a six and one-half months' fœtus was delivered, without rupturing the sac. The placenta followed immediately. I then introduced my hand into the vagina, with two fingers in the uterus. Portions of membrane, blood-clots, etc., were secured in considerable quantity. The uterus was then thoroughly irrigated with a 1 to 6 peroxide solution, and the patient allowed to rest. She had a degree and one-half of temperature the next day, but no further trouble.

She was discharged October 17th, or one week from date of entrance, apparently in perfect health. The cause of the death of the fœtus is unknown.

CASE III.—*Induced miscarriage at six and three-quarter months for pyonephrosis.* Mrs. C. M., age 20; housewife; entered the hospital October 9th, six and one-half months advanced in gestation, and with a septic temperature chart varying from 97 to 104 degrees. General condition very poor indeed. Pain over right kidney, worse on pressure. Whole abdomen also very sensitive, especially over the bladder. Strangury and tenesmus of bladder, with frequent micturition, while the whole quantity of urine for twenty-four hours was very small. Stom-

ach was irritable, and solids could not be taken; neither could broth and milk be retained, but beef juice and peptonoids were tolerated.

Urine chart upon entrance was as follows: Sp. gr. 1004; urea .006; albumin present, and pus in abundance. Bladder epithelia present from middle and upper portions.

Labor induced *October 17th*, 10 A.M., by dilatation of the cervix and rupture of membranes, which contained a large amount of liquor amnion. Patient went on to normal labor—although there was good evidence of labor pains before the interference. At 2.30 same day she gave birth to a three-pound male child, which lived several hours.

October 18th.—Temperature normal in the morning; in the evening $103\frac{1}{5}^{\circ}$; pulse 120.

Urine chart: Quantity during last twenty-four hours, 34 ounces; sp. gr. 1008; albumin present, though in much less amount than at previous examination; urea .011 per cent.; pus and renal tubules abundant.

October 19th.—Morning temperature $99\frac{2}{5}^{\circ}$; pulse 96. Evening temperature $103\frac{1}{5}^{\circ}$; pulse 120.

Urine chart: Sp. gr. 1010; albumin present; urea .008; blood abundant; pus present, and renal epithelium.

October 20th.—Morning temperature 97° ; pulse 98. Evening temperature $99\frac{3}{5}^{\circ}$; pulse 112.

October 21st.—Morning temperature $98\frac{5}{10}^{\circ}$; pulse 88. Evening temperature 99° ; pulse 96.

Urine chart: Sp. gr. 1012; albumin present, though in small amount; urea .009; blood present; pus absent. Crystals of triple phosphate abundant.

October 22d.—Morning temperature 99° ; pulse 80. Evening temperature $99\frac{1}{5}^{\circ}$; pulse 84.

October 23d.—Morning temperature $98\frac{4}{5}^{\circ}$; pulse 80. Evening temperature $98\frac{2}{5}^{\circ}$; pulse 88. Appetite returning and general condition good, though urine chart of this date still showed evidence of some pus and albumin.

Patient was then transferred to the women's ward to continue her convalescence, all puerperal symptoms having disappeared.

November 7th.—The date of her discharge from the hospital her general condition was excellent, she having gained con-

siderably in weight and strength, and was now eliminating 35 ounces of urine in twenty-four hours, while the albumin, pus-cells and tube-casts had entirely disappeared.

CASE IV.—*Induced miscarriage at four months for prolapsed funis.* Mrs. A., age 33; multipara; has had six children and six miscarriages; case sent to the hospital by Dr. L. J. Sanders. Patient entered hospital in the afternoon of March 8th, four months advanced in gestation. She was not in labor, but on examination the funis was found prolapsed in cervix, which, of course, indicated membranes had been ruptured, and abortion was sooner or later inevitable. Patient was prepared and placed on the table at 6 P.M., and one yard of iodoform gauze, narrow width, was inserted within the cervix by means of the intra-uterine packer, and reinforced by vaginal packing. Patient was returned to her bed, and had frequent sharp pains in pelvis until about 6 o'clock the next morning, when she gave birth to a fœtus of about four months' development. The placenta was retained, and at 7.15 the vagina was packed, but the packing was expelled in about an hour. At 10 A.M. the cervix was dilated manually, and the placenta was delivered by means of the placental forceps and hand. The uterus was then cleansed with a solution of bichloride 1-6000, followed by sterile water. The after-treatment consisted of two carbolic douches daily, with indicated remedies. Patient left hospital on the seventh day in excellent condition.

CASE V.—*Induced, or rather precipitated, labor at term, to save the life of child; breech presenting.* March 16th, in consultation with Dr. W. S. Rambo, for Mrs. L.; primipara; age 30. Labor had progressed slowly for a time when the doctor diagnosed a breech presentation through a somewhat dilated and dilatable cervix. Upon my arrival I confirmed his opinion, and proceeded at once, with the patient under chloroform, to deliver the child. At first some traction was made with the finger in the groin of the infant, but without much success. The antero-posterior diameter of the pelvis seemed a little contracted, and the body of the child somewhat twisted in the uterus. Two unsuccessful attempts were made to change the presentation into a cephalic one. It seemed impossible to cause the head to take a position in the cavity of the false pelvis with the hand in the uterus. Furthermore, the patient was consid-

erably distant from the edge of a low bed, making manipulation more difficult. The feet were then grasped, being hooked over the head as though on a horizontal bar, and brought down carefully to avoid dislocation or fracture of the legs. As they came down into view the cord followed suit, and could not be returned. The back of the child was at the symphysis pubis. A towel was then wound around the legs of the infant, and they were grasped firmly with the left hand. The right hand was then introduced within the vagina, and the occipito-mental diameter of the head changed to the occipito-frontal by pressure on the cheek bones and the fingers in the mouth of the child. In other words, the chin was not allowed to leave the chest. The child was then quickly delivered, and after a little effort it showed signs of life. In a short time it was fully resuscitated and cried heartily. The after-birth was soon secured and the patient allowed to rest.

There were no complications following for either mother or child.

CASE VI.—*Induced, or rather precipitated, miscarriage at seven months, for supposed dead fœtus and tuberculosis.* Mrs. C., age 31; primipara; sent to the hospital on afternoon of March 20th by Dr. B. R. White, of Honeoye Falls. Patient gave history of pregnancy advanced to about seven and a half months. Quickening was first noticed November 18th, and had continued since that time until five weeks ago. About October 1st patient began to cough, and has coughed constantly since this time and expectorated freely. Dr. White informed us that she had been running a temperature, night and morning, for several weeks, varying from 100 to 102 degrees. Patient stated that she had not noticed any further enlargement of the uterus for five weeks, and had not felt the movements of the fœtus during this time. A sample of the sputum was sent to the health department for examination, and report afterwards received stated that it was tubercular.

During the day of entrance she had occasionally complained of intermittent uterine pains, and upon examination at 5 P.M. the cervix was found dilated about two inches in diameter, and was quite soft and dilatable. The fœtal pulsations could not be detected with the stethoscope, and the uterus was not distended to correspond with a seven and one-half months' gesta-

tion. Breasts were full and rather prominent, but the abdomen was not enlarged beyond a four and one-half months' development.

After examination, patient was placed upon operating-table, with a view of inserting iodoform gauze within the cervix, to facilitate labor and conserve her energies. Chloroform was administered, and the hand was inserted within the vagina, to make a more extensive and careful examination. The cervix being soft, this was easily accomplished, the breech was found presenting, and I decided to deliver at once, and not wait the effect of gauze to be inserted or natural expulsion. In a few moments the uterus was entirely emptied of a four and a half months' dead fœtus and placenta. The uterus was then held firmly against the symphysis to prevent hæmorrhage, and irrigated with hot peroxide solution, 1-6, followed by sterile water. There was no laceration of the cervix or perinæum. Her temperature remained the same until the third day, when it rose to 105 degrees and her pulse to 140 for a short time. Digitalis 1x was administered to stimulate the heart, and the pulse came down 20 beats in an hour. The temperature and pulse were soon better, the former about 102 degrees, while the latter varied from 80 to 90 per minute. She had no puerperal symptoms whatever, and has been removed from the maternity to the medical side of the hospital. Her ultimate recovery is hardly to be expected.

These cases of so-called obstetrical interference are herewith presented, not only on account of their intrinsic interest, but also as illustrating the various procedures which may be adopted to facilitate certain abnormal conditions in pregnancy of which these cases are types.

In the first case, for instance, we were confronted with one of the most serious conditions in obstetrical practice—that of uræmic convulsions. After considerable experience, we have arrived at the conclusion that in these cases the uterus must be emptied, and at once, whether the patient is in labor or not. It is of little moment whether the cervix or perinæum is lacerated if the life of the mother, and possibly that of the child, may be saved by interrupting pregnancy without delay. Other complications attending rapid delivery are infrequent and controllable, as hæmorrhage, shock, traumatism, etc.

There is great danger to mother and child by trusting to natural expulsion of the fœtus.

In the case of a dead fœtus, while it will be admitted that the uterus usually will be equal to the emergency, and will empty itself of this now foreign body in a month or six weeks at the most, and this, in the majority of instances, without septic infection to the mother, yet, when once we are positive of the death of the fœtus, there is no occasion whatever for delay, as interference under proper circumstances is seldom, if ever, followed by unpleasant results, and the patient is thereby relieved of unnecessary waiting and possible infection.

The best method to accomplish this purpose with which I am familiar is the insertion of gauze within the cervix. The method is as follows: after the patient is prepared with a bath, douche and enema, a bivalve speculum is inserted, the anterior lip of the cervix is seized with a volsella, and drawn somewhat into the speculum. The cervix is then forcibly dilated with a Wylie dilator sufficient to admit the intra-uterine packer. A yard of gauze, preferably iodoform, is then inserted between the membranes and the uterus, and the packer withdrawn. It is unnecessary to rupture the membranes; in fact this is to be avoided, if possible, in septic cases. The vagina is then quite tightly packed with sterile gauze, to hold the intra-uterine gauze in position, and also for its reflex irritating effect upon the uterus in producing labor pains. In twelve to twenty-four hours these will regularly appear, the gauze will be expelled, the cervix will dilate, and the fœtus, if not yet expelled, can easily be secured.

In the third case, that of pyonephrosis, the cervix was dilated and the membranes ruptured, but there was no gauze inserted. There was a large amount of liquor amnion, the patient's general condition was very poor indeed, and it was thought that on account of the uterus now being relieved of this unusual distention it would soon expel its contents, which it did in four hours.

In the fourth case, that of prolapsed funis, at four months, the treatment followed corresponded with that already described for dead fœtus.

In breech presentations interference is often necessary and

desirable. When the patient is seen early, and she can be placed on a proper bed or table for manipulation, this position can be changed for a cephalic one, which, of course, is more desirable, and not so dangerous to the child on account of compression of the cord by the passage of the head through the pelvis. In cases where it is impossible, for any reason, to accomplish this purpose, the more rapid the delivery, without undue traumatism, the better.

The treatment of the last case reported, that of precipitated miscarriage at seven months, for supposed dead fœtus and tuberculosis, does not differ materially from the one of pyonephrosis, except that in the former the cervix was so soft and dilatable, and the breech so accessible, it was thought best not to wait longer, but to empty the uterus at once.

De Marini, who is assistant to Professor Bossi, University of Novara, contributes an article on Tuberculosis and Pregnancy, a synopsis of which is published in the January, 1901, number of the *Journal of Tuberculosis*, in which he states it is not only important to determine the effect of pregnancy upon consumption, but we ought also to learn what effect consumption has on the course of pregnancy and on the fœtus. After discussing the matter somewhat at length he arrives at the following conclusions, which are presumably those of Bossi himself:

1. Pregnancy, and especially parturition (by reason of the lost blood and impoverished energy) have a pernicious effect on tuberculosis.

2. Tuberculosis has a disturbing action on the course of pregnancy and the fœtus.

3. If the fœtus survives, a tuberculous unit is added to society.

4. Intervention should be by the most rapid and least laborious method. Krause's method of terminating pregnancy is advised where urgency is not required, while in the opposite case the Bossi method is employed.

Among the newer reasons justifying the induction of abortion, miscarriage or premature labor, as reported in the *American Year Book of Medicine and Surgery* for 1900, the following are mentioned:

1. Uncontrollable vomiting, which very rarely indicates the operation.
2. Renal disease, especially interstitial nephritis,

when a milk diet does not decrease the albumin. 3. Advanced pulmonary disease. 4. Cardiac trouble, only when the dilatation is not compensated by the physiologic hypertrophy of pregnancy. 5. Chorea, in extreme instances, in hope of benefiting the condition, and to prevent insanity. 6. Pelvic deformity that will not permit the induction of premature delivery, and unless the mother elects a Cæsarean section. 7. Cancer of the uterus, only when the disease is too far gone to wait for viability or the woman refuses the Porro operation.

THE THERAPEUTIC INDICATIONS AFFORDED BY THE CARDIO-VASCULAR CHANGES OF CHRONIC NEPHRITIS.

BY F. MORTIMER LAWRENCE, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the County of Phila., April 11, 1901.)

THAT the early recognition of a chronic nephritis is of vital importance to its successful treatment will not, I think, be disputed. That a comparatively small proportion of these cases are so recognized, however, the enormous mortality-rate from Bright's disease attests. It is not surprising, for a more insidious disease—I am referring particularly to the chronic interstitial form of nephritis—does not exist. In fact, it is only by the application of routine diagnostic measures to every case of illness that we can expect to discover early even a fair proportion of the many granular kidneys. In far too many cases it is only by the onset of uræmia, acute or chronic in its symptomatology, that attention is called to the renal condition; and often it is the autopsy after a sudden death which discloses in contracted kidneys the unsuspected cause of dissolution. I need not remind you, I think, that our pathologists have ceased to award to heart disease first place among the causes of sudden death, and that, instead, it is to the kidneys that responsibility can be traced in by far the larger proportion of cases. The statistics of any hospital whence are conveyed the unfortunates picked up dead or dying in the streets will prove this assertion. For instance, the record of post-mortem findings in patients taken moribund or dead to one London hospital showed that

in 48 per cent. the fatal disease was renal. Under such circumstances we cannot consider too carefully the means at our disposal for the early diagnosis, and if possible the arrest, of chronic nephritis.

The almost constant association of cardiac and arterial changes with renal sclerosis is well known. It is not essential that we decide which of them is primary; in all probability it is sometimes the kidney which is first affected; and, again, the change occurs first in the vascular system. Two objective conditions are of distinct importance: the hypertrophy, often enormous, of the left ventricle of the heart; and the hardening of the arteries. These are so conspicuous that in many cases we need not wait for a urinary examination to determine our diagnosis. For example, an unconscious man is picked up in the street and hurried to the hospital by the police patrol. We examine his chest for the heart apex, and find it displaced downwards to the sixth, seventh or eighth interspace, and outwards to or beyond the nipple, even to the mid-axillary line; and as a necessary corollary to this, the second sound in the aortic area is sharply accentuated. Even while the examining finger is noting the rigid, tense pulse, and before the urine withdrawn by catheter has shown the presence of albumin, our diagnosis is made—uræmic coma.

It is not my purpose, however, to discuss the cases rendered ultimately hopeless by the onset of uræmia. The latter represents a final stage, one in which no treatment can procure more than temporary relief. Let us, instead, go back to the earlier stage, that in which cardio-vascular changes are already marked, but in which enough renal parenchyma yet remains intact to afford hope of continued life if only the sclerotic process can be checked. Let us emphasize the fact that in this stage we have to deal with a general, not a local, process; and it follows, obviously, that this general sclerotic tendency, already manifest in heart and arteries, must dominate our therapeutics.

This brings us to the question of cause. I believe it to be a fact that practically all cases of interstitial nephritis not syphilitic in origin are due to gout. Lead-poisoning may predispose, alcoholism may predispose, but the action of either of these is simply to produce that disorder of metabolism which is known to us clinically as the uric acid diathesis. It is knowl-

edge of this, the presence in the blood of certain substances resulting from the ingestion of unassimilable food, or representing the product of its imperfect metabolism, which offers a starting-point for rational treatment. As to what should be done, we are all, I trust, agreed; but we must modify the general dietetic and hygienic regulations appropriate for the average gouty patient with careful reference to the degenerative changes already present in the individual. For instance, the rather active out-of-door exercise which we would recommend to the gouty man with sound arteries must not be prescribed for him whose arteries are already brittle; for if it were, far too often a fragile vessel would snap and cerebral or other hæmorrhage close the scene.

To what extent, then, should we modify the manner of living of the patient in whom we have detected an early nephritis? Since uric acid results from the imperfect oxidation of nitrogenous products, two indications are paramount: to decrease the quantity of proteid ingested and to increase the amount of oxygen in the tissues. The first we accomplish by means of the dietetic restrictions familiar to you all; the second we endeavor to bring about by encouraging life in the open air. If our patient is a business man, we insist that he limit his hours at the office, and that a certain definite proportion of his hours of freedom shall be spent out of doors. Here, however, the question of exercise requires careful consideration. It may be permissible, if arterial change be slight, for the patient to indulge in bicycling at a modest pace or devote himself to golf; and under any circumstances but those attending heart failure we can advise leisurely short walks in the open. Violent exercise must be omitted, however; running or lifting is forbidden, and even strong excitement must be avoided. In the meantime, even in the earliest stage, it is well to spare the kidneys all unnecessary strain by aiding skin elimination; and we accomplish this by daily tepid or even hot baths, and the wearing of warm woollen clothing. Removal to a warm, moist climate during the cold months is advised for a similar reason, lest sudden chilling of skin surface, by throwing increased blood pressure upon the kidneys, precipitate their failure.

It is in this stage that most can be expected from carefully selected medicines. Unfortunately, in the days of our early

provers pathology was a matter of theory rather than exact observation, and we have little knowledge of the material changes induced by even our most important drugs. One remedy, however, seems constantly to prove itself applicable, both symptomatically and clinically, to the gouty state, and that is *rhus toxicodendron*. To be sure, its reputation is pre-eminently that of a rheumatic remedy; but we must acknowledge that it is quite as often curative in so-called muscular and other "rheumatisms," which are in fact not the infection properly so named, but rather manifestations of the gouty diathesis. Moreover, the undisputed relationship of *rhus* to fibrous tissues explains its value in these cases.

As may be surmised from its direct causal influence in a certain proportion of the cases, lead produces the exact clinical picture that we have been considering. It must be acknowledged that *plumbum* has not distinguished itself by proving curative in nephritis, however. Possibly the explanation suggested by Goodno, that we are all more or less the victims of *plumbism*, is the true one. Nevertheless, while *plumbum* has disappointed some of our expectations, it is of great value when, in the absence of lead-poisoning, the gastric and visceral symptoms of that poison appear.

It might, I think, be made into a maxim, that the prognosis of any chronic disease is governed by the amount of connective tissue present. We have not, nor can we hope ever to have, any drug capable of causing the absorption of fibrous tissue. Our utmost hope is that we may be able to prevent its further formation, and for this purpose many remedies have been tried. One of them, the chloride of gold, seems to have vindicated its reputation by clinical results. It must, of course, be given early and persistently, and it is in this same early stage that neurotic symptoms afford additional indications for its use. A suspicion of syphilis but adds to its applicability. It is interesting to note that this remedy, revived by Hahnemann after centuries of neglect, is now recommended by Bartholow and other therapeutists for the very condition in which it has yielded us such satisfactory results.

A fourth remedy, and one with a reputation based upon repeated clinical successes in the hands of practitioners of all schools, is corrosive sublimate. To be sure, it has been sug-

gested that these cures may have been due to an undiscovered syphilis underlying the kidney lesion; but from its toxic action on the kidney it seems probable that it is often indicated irrespective of any such etiologic factor. Mercury and arsenic are among the very few drugs which produce, experimentally, a marked increase in the quantity of solids excreted by the urine. This indicates, however, an action upon the renal parenchyma, and may justify the assertion that the chief value of *mercurius corrosivus* is in case of secondary or intercurrent involvement of the tubular epithelium.

These are, of course, but a few of many remedies useful at this stage; others find their indications in the dyspeptic or neurotic symptoms, or perhaps the headaches, which form so large a proportion of the subjective complaints at this period.

We have already suggested, in discussing the amount of exercise advisable, that one of the dangers, outside of uremia, most to be dreaded, is the rupture of an artery. A second, which usually occurs late in the course of the disease, is cardiac failure. In a certain proportion of cases the degenerative changes in the heart-muscle are in excess of those in the kidney itself, and, as a result, compensation fails without the immediate supervention of uremia. Then an interesting diagnostic difficulty, which I mentioned in a recent number of the *HAHNEMANNIAN MONTHLY*, presents itself. There is evident lack of cardiac compensation; the circulation is embarrassed, the quantity of urine is diminished, it is increased in specific gravity and coloring matter, and contains albumin and casts. Is it merely a congested kidney secondary to heart disease? Murmurs, which are rarely present in the hypertrophied heart of chronic nephritis, also disappear with increasing dilatation of a heart primarily diseased; and, on the other hand, the heart dilatation secondary to renal disease may develop relative incompetency and a murmur; so these physical signs afford no aid in diagnosis. In the absence of an exact history, the cause of the condition can still, however, be determined by attention to three facts:

1. In congestion of the kidney the casts are usually hyaline only.

2. Venous congestion tends to become general, involving liver, spleen and serous cavities, and merging into general anasarca.

3. The subsidence of venous congestion upon restoration of compensation is associated with complete disappearance of albumin and casts from the urine.

Fortunately the distinction of these two states is of prognostic rather than therapeutic importance. The treatment is that of broken compensation, whatever its cause. The patient must be put at rest, and if his symptoms be confined to dyspnoea, throbbing headache, vertigo, etc., the best remedy is glonoin. Instead of the solution or tablets, I use pellets medicated with the one-per-cent. solution, adding a definite number of drops of the latter to enough pellets to take up the drug; by counting the latter, the exact dose represented by each may be estimated. By the use of these the remedy can be given in small doses every hour or two until the desired effect is obtained. It must be remembered that the value of nitroglycerin in reducing the arterial tension, which is unquestionable, depends upon sufficient dosage; and sometimes this is large as measured by ordinary standards. At the same time it must not be forgotten that high arterial tension is, in part, a conservative condition, since it carries the blood to the kidney under such pressure that elimination is increased. We must not, therefore, lessen it too far.

Finally, there may arise such complete compensatory failure that dropsy appears, and we are compelled to resort to the physiological heart-stimulants. As a rule, caffeine should first be tried for the control of this condition, and should it fail, calomel may be given in repeated small doses. I have already mentioned the action of mercury in increasing the elimination of solids, and so it is doubly useful in this condition. Only after its failure would I resort to digitalis; but if the latter be given, let the dose be a full one, continued for a week or ten days, and then stopped. If no improvement has occurred, strophanthus may be tried in turn; in fact, in theory, but unfortunately not in practice, the latter is a better-indicated drug than the other. Give it, too, in full doses; for the case is desperate, and our best efforts can produce but temporary palliation.

Should temporary restoration of compensation occur, our treatment must continue to be directed to the heart. Often it is necessary to give strychnine continuously, and in actual emergency we may resort to camphorated oil hypodermatically.

Should the pressing necessity for such medication pass away under the influence of continued rest and nutrition, we may be able to preserve the heart's efficiency for some time by the use of arsenic iodide or cactus.

That many other therapeutic measures may be of value in these cases is unquestionable. For instance, in no class of patients are the Nauheim baths so valuable; but limitations of time and space forbid my enlarging upon that topic. I venture to hope, however, that you will agree with me in my main contention: that in the cardio-vascular changes we find the dominant indications for the treatment of chronic nephritis.

THE THERAPY OF ACUTE AND CHRONIC INFLAMMATIONS OF THE URETHRA.

BY LEON T. ASHCRAFT, A.M., M.D., PHILADELPHIA.

(Read before the Homœopathic County Medical Society, April 11, 1901.)

Mr. President and Members of the Society: Since lack of time forbids mentioning the treatment of every diseased condition of the genito-urinary organs, my remarks will be confined to urethrites. We recognize clinically a urethritis caused by the gonococcus of Neisser: one due to a mucous patch or a chancreoid or herpes; also tuberculosis of the urethra. It may, too, arise from an excess of uric acid or from traumatism. Or, excessive intercourse with a partner who suffers from a leucorrhœal discharge. Such a type simulates closely the Neisserian variety. Gonorrhœal urethritis is most important, not only because of the distress which it affords the patient, but also because of the complications which too frequently arise from it. The prophylactic, dietetic and hygienic treatment is too well known to discuss. Are the best results obtained by surgical or medicinal measures, or by a judicious combination of both? About three years ago I treated twenty cases of acute urethritis by internal medicine, homœopathically prescribed; twenty with copaiba and methylene blue; twenty by purely local antiseptics, applied by the Valentine method; twenty by a combination of homœopathic remedies and the irrigation

method of treatment. The indicated homœopathic remedy cured the majority within six weeks—five cases developing posterior urethritis, and four becoming chronic. Those who received methylene blue and copaiba suffered very little in the earlier stages, but later, when the drug was discontinued because of gastric disturbance, the urethritis recurred. Here it was not uncommon to see chronic urethritis, posterior urethritis and epididymitis develop. Four of the cases treated by Valentine's system of irrigation developed posterior urethritis; three became chronic, while the majority were cured in about five weeks. With the desire to perfect the treatment, it was decided to try a combination of both irrigation and homœopathy, with the gratifying result that but two cases of posterior urethritis developed, two became chronic, and the majority were cured in about twenty-five days. This treatment we have adopted. It is both rational and scientific, insuring the promptest recovery, together with a minimum of complications. Antiseptic irrigations destroy the germs and internal remedies subdue painful features. Perhaps it may prove interesting to mention the remedies employed. Specific urethritis, invading the anterior urethra, passes through several stages, even when influenced by treatment. Therefore each stage demands specific remedies. In the stage of invasion, when the cocci enter the urethra, they do not penetrate very deeply into the intercellular spaces, as the flat epithelium of the anterior fossa resists microbial invasion. Therefore, there is very little discharge and very little pain, but slight burning on urination. Gelsemium, then, is the remedy. It should be given in drop doses of the tincture, repeated hourly; it does but little good after thirty-six hours, since by this time the cocci, having invaded the region posterior to the fossa navicularis, produce another type of inflammation. Here germs come in contact with cylindrical cells, invade the intercellular spaces, and reach the uppermost layer of connective-tissue. Now we have to deal with an active inflammation, modified, of course, by several circumstances—namely, by the severity of infection, by the resistance afforded by leucocytosis, and the peculiar inherent ability of all tissue to resist injury. Aconite is a remedy of decided value; it should be given early and often. The indications for its administration are frequent, painful urination, burning, and

a muco-purulent discharge. *Cannabis sativa* and *clematis* follow well, and may be differentiated. Later, however, when the battle takes place between the polynuclear leucocytes and the gonococci, there is a purulent discharge, sometimes associated with blood, frequent and painful erections, particularly at night, and burning during urination. Now a different class of drugs is demanded, as *argentum nitricum*, *capsicum*, and *mercurius solubilis*. In the very acme of inflammation, this latter drug is a magnificent remedy. Likewise *camphora*, it being particularly efficacious in ameliorating the painful affections of chordee. Other remedies which relieve chordee are *agave* and *cannabis indica*. *Terebinthina* is, too, of occasional service. After leucocytosis succeeds in bringing the cocci to the surface of the urethra, the picture changes, and another class of remedies should be selected. Sulphur heads this list, since it has in its pathogenesis burning, soreness, redness of the labia, and thick, yellow, purulent discharge. *Thuja* should follow sulphur; the indications are about the same, except that in this drug a greenish discharge predominates. The declining stage is best suited to *hepar*, *hydrastis* and *pulsatilla*. Although there are those who still question the efficacy of local measures, yet I am sure that if they would lay aside their prejudices, accept the consensus of medical opinion, and give this plan a good, fair trial, using it always in conjunction with their internal prescriptions, they would be delighted with the results.

Much of the adverse criticism which has been heaped upon this method of treatment owes its origin, not to the conscientious practitioner, but to him who recklessly allows the patient to follow his ideas concerning local treatment. It is not my purpose to dwell upon the various methods of local treatment; they have been mentioned in one of my former articles.* Suffice it to say that I now employ the irrigation method introduced by Janet, popularized by Valentine, and employed now almost universally. I have used it in both public and private practice for the past five years, and attribute my results to its judicious employment, combined, of course, with internal remedies.

* See "Treatment of Specific Urethritis," *HAHNEMANNIAN MONTHLY*, June, 1896.

In the early stages I use a 1-2000 solution of permanganate of potassium. During the stage of inflammation, I add to this a solution of 1-20,000 bichloride of mercury. In the stage of decline, 1-2000 permanganate of potassium and 1-500 sulphate of zinc. Finger (Vienna), and Carlton (New York) laud highly the silver preparations, preferably protargol, and rely mainly upon it when employing local methods. Should posterior urethritis develop, the treatment, of course, changes. It is but necessary to recall the anatomical relations of the posterior urethra to the prostate and bladder to understand why local treatment is now positively harmful, since by driving the pus into these organs grave sequelæ will undoubtedly develop. Internal remedies act most brilliantly in acute specific posterior urethritis. Should it commence insidiously, as it usually does, with a frequent desire to urinate, together with a sense of fullness in the perinæum and an inability successfully to expel the last drop of urine, kali bichromicum is indicated. Should the attack begin more acutely, associated with a desire to urinate every ten minutes, together with great perineal distress, petroselenium should be given. When these symptoms co-exist, and the urine is admixed with blood, terebinthina is of great value. In hyperacute cases, where all of these features are greatly exaggerated, much relief has been afforded from cantharis, and occasionally from aconite. As the inflammation subsides to a subacute form, nux vomica and stillingia are very useful. Acute periurethral inflammations, such as folliculitis and Cowperitis, demand evacuation of the encysted pus; otherwise fistula and urinary extravasation may result. Acute inflammation of the balano-preputial layer is best combated by washes of a 1-2000 solution of permanganate of potassium. Should complete phimosis occur, a dorsal slit, or even circumcision, is advisable. To some this may appear to be quite heroic, yet it is indicated for these reasons.

A long, tight foreskin acts as a receptacle for urethral discharges, thus constantly affording the urethra a source of renewed infection. Paraphimosis has not infrequently yielded to apis. Of course, a very tight constricting band disappears only by sloughing or by severing it. The treatment of chronic inflammation of the anterior urethra depends entirely upon the type present. Clinically we recognize a superficial variety in

which a low-grade catarrhal inflammation exists; also a deep type where the foci of inflammation are distinctly localized. In the former it is good treatment to continue with the irrigations and the use of the internal remedy which has been previously prescribed for the stage of decline of acute urethritis. Usually the urethra will demand tone, and such can be obtained by the judicious use of sounds and dilators; they are beneficial, since they express from the diseased follicles their morbid products, and also because they produce absorption of plastic products. A detailed description of their employment has been given in one of my former articles.* Quite a number of cases owe their continuance to erosions, demanding urethroscopy; the lesions, having been located, should be touched with a 4 per cent. solution of nitrate of silver every three days until the necessity no longer exists. Chronic deep anterior urethritis demands for its cure strict dietetic and hygienic measures, together with medicinal means. A large majority owe their continuance to a stricture of large calibre, and before any other measures are considered it is our duty to explore the urethra for such. Should any be found, it is imperative to remove them, either by meatotomy, urethrotomy, or gradual dilatation, the choice being determined upon by their character and location. This point I cannot too strongly emphasize, and insisted upon such two years ago in a paper before this Society.† Not until the canal has been thoroughly freed from abnormal narrowings can we ever hope to effect a cure; and after such has been done, if the patient is not well, he can be made so by careful diet, hygiene and good prescribing. The remedies which should be employed are calcarea phosphorica, natrum muriaticum, natrum sulphuricum, and silicea. It must not be forgotten that in this condition urethroscopy is a valuable therapeutic aid. Before dismissing the subject it must not be forgotten that gleet may arise from chronic inflammation of the posterior urethra, prostate or seminal vesicles.‡ §

Chronic folliculitis and chronic Cowperitis, if present, may prove rebellious and alone cause a chronic urethral discharge.

* See "Causes and Prevention of Urethral Stricture."

† "Diagnosis and Treatment of Chronic Prostatitis."

‡ "Seminal Vesiculitis." Reprint from the *HAHNEMANNIAN MONTHLY*, 1899.

§ "Diagnosis and Treatment of Urethral Stricture of Large Calibre."

They are treated by topical applications through the urethroscope. Chronic posterior urethritis, like the anterior type, presents both the superficial and deep varieties of inflammation. Where the superficial process is limited to a small area, the symptoms can usually be dissipated by topical applications. It is my custom to instil upon the surface affected nitrate of silver, by means of the Keyes-Ultzmann syringe, commencing with one-half grain to the ounce and repeating every other day, increasing the strength to a solution of forty or even fifty grains to the ounce. My reason for rejecting internal remedies may be explained by saying that sufficient symptoms are lacking upon which to make an intelligent prescription. Where the inflammation assumes a diffuse type, instillations are rejected in favor of deep irrigations of 1-4000 solution of permanganate of potassium. Here the complexity of symptoms affords liberal opportunities for internal medication. Irritation of the caput gallinaginis, manifested by marked seminal emissions, together with frequent desire to urinate, associated with burning and pain in the perinæum, may be relieved by agaricus; petroleum is also well indicated. Chronic deep posterior urethritis frequently involves the prostate and its appendages. The therapy of this type includes a consideration of pelvic gonorrhœa, and indeed of the whole field of sexual neurasthenia. This can be appreciated when we consider the numerous reflex symptoms arising from irritation of the prostatic urethra. The symptoms are mostly referable to the genito-urinary, sexual organs and rectum. The urinary symptoms have been ameliorated by aconite, belladonna, cannabis indica, cantharis, mercurius corrosivus and pulsatilla. Urinary and rectal symptoms have been controlled by muriatic acid, phosphoric acid, aloes, alumina, ambra grisea, argentum nitricum and staphisagria. Phosphoric acid and sulphur are decidedly well indicated when the triple combination of urinary, sexual and rectal symptoms coexist. Sexual symptoms have been relieved by fluoric and nitric acid, agaricus, agnus castus, calcarea carbonica, cannabis sativa, cinchona, cantharis, capsicum, kali bromatum, kali iod., lycopodium, mercurius corrosivus, natrum carbonicum and nux vomica; and particularly by salix nigra, phosphorus, selenium, silicea and staphisagria. It must be distinctly understood that these remedies alone by no means suf-

fice to thoroughly eradicate chronic posterior urethritis. Other measures must be employed. Irrigation with permanganate of potash 1-4000 must be given every five days. Intermittent dilatation with Guyon's posterior dilator is also of decided value. It must be remembered that where prostatitis coexists, brilliant results are obtained usually by local treatment. Should every therapeutic measure fail to cure the discharge, and increased frequency of urination, strangury, pain, perineal and rectal distress exist, then perineal section is decidedly indicated. Such I have been compelled to do. It is beneficial, since during anæsthesia the irritable sphincter vesicæ can be overstretched, and by placing a tube in the bladder it not only favors drainage but allows the much overworked muscle a rest. Incurable cases are usually those in which gonorrhœa and tuberculosis coexist. Non-specific urethritis needs only homœopathic remedies. Syphilitic urethritis may be treated by topical applications through the urethroscope. Traumatic urethritis demands internal remedies. Likewise uric acid urethritis. Here lycopodium is distinctly indicated; also phosphoric acid and nitro-muriatic acid. This latter remedy should be given in drop doses, well diluted, after each meal. *Berberis vulgaris* has, too, proven efficacious. Of course the patient, who is constantly manufacturing uric acid, must be given a suitable regimen. Animal food must be interdicted, substituting milk, fish, eggs and vegetables. Wine is poisonous. In habitues it is well to allow a little well-diluted whiskey. Alkaline beverages should be drunk. Free bowel movements should be encouraged. Tubercular urethritis is decidedly important, because of its gravity and tendency not to respond to apparently well-directed methods. No matter what is done, cures rarely follow. It must be remembered that the condition is usually secondary to a similar state of the prostate, bladder or kidney, although occasionally it arises independently. When this is the case, provided the ulcer can be seen, it may be cauterized or even curetted, and, if near the meatus, cut out. Local treatment usually adds to the patient's discomfort, and not infrequently causes urethral fever. Where urethral tuberculosis is secondary, local treatment is useless. Internal remedies rarely cure. Those selected, however, should endeavor to cover these symptoms: Profuse muco-purulent and, at times,

sanguino-purulent discharge, redness of the labia, tenderness along the urethra, frequent desire to urinate, always associated with pain before, after and principally during the act, the pain being referred to the middle of the urethra. Intermittency of urination, too, is a prominent symptom. Unfortunately, however, a palliation is all that can be promised.

DIFFICULTIES IN A HOMŒOPATHIC PRESCRIPTION.

BY W. S. SEARLE, A.M., M.D., BROOKLYN, N. Y.

(Read before the Brooklyn Medical Club and the Homœopathic Medical Society of Kings County, N. Y.)

For the purposes of the present discussion we will assume that *Similia Similibus Curanter* is a law of nature, and, when competently applied, a broad and effective one. The limits of its sphere and its relations to other therapeutic laws we cannot now consider. But, as Captain Cuttle was fond of remarking, "The bearings of this here proposition lie in the application on't;" so we may assert that the value of this or of any other law of nature depends upon our ability to make practical use of it. Now, it seems obvious to me, and I presume to all who have attempted to employ this law in the treatment of the sick, that it differs from most, if not all other, natural laws in respect to its feasibility of application. The laws of astronomy, of chemistry, of electricity, etc., those who are expert in them can and do apply without difficulty, and much to the advantage of mankind. Other laws of cure, too (assuming them to be laws), such as "contraria," "differentia," those of hydro-pathy, serum-therapy, etc., are utilized without serious difficulty. But no one can long attempt to practically apply the law of *Similia Similibus Curanter* without discovering that he has undertaken no holiday task. I assert what every honest and competent homœopath will admit when I say that failure in such attempts, even by experts, is more common than success.

That the latter occurs often enough to confirm our faith in the essential verity of this law I readily grant. I also admit

that (within the proper sphere of this law) the fuller and more accurate our knowledge of the *Materia Medica*, the wider our experience, the greater our genius, the more frequent and satisfying our success. But still it must be owned that in practical, everyday employment of this law we meet with great, and at times insurmountable, difficulties. By careful and diligent study we do, not seldom, make brilliant cures. But why are these not the rule rather than the exception? And if they were the rule, how long would it be before the essentials of homœopathy would be universally adopted?

Now let us glance at some of the difficulties referred to, and try to discover how they may be overcome, or at least minimized, so that with more rapid strides we may approach our ideals.

The most important obstacle is found in our *Materia Medica*. Hahnemann entitled it the *Materia Medica Pura*, evidently expressing rather his conception of what it ought to be than its actuality.

But to-day, after a century of trial, its impurity is largely in evidence. So many have been the criticisms of this monumental work—monumental both for its verity and value, and for its falsity and fallaciousness—on the part of physicians whose knowledge of it and of its sources entitle their conclusions to respect, that I shall not attempt even a summary of them here. Nor shall I indulge in more than a single remark thereon.

To cite errors and pick flaws in our *Materia Medica* is easy, but contributes nothing to reform. Long ago I became convinced that attempts to sift the wheat from the chaff in the *Materia Medica* are dangerous as well as impracticable, and I believe that this is also the opinion of our greatest experts in this field.

But still I am sure that something must be done; somehow we must obtain a new and more modern *Materia Medica*, if we expect ever to have one that will commend itself to the medical profession in general, and prove reliable in our own daily practice. How can we wonder at the smiles and sneers of modern physicians as they turn the pages of the “*Guiding Symptoms*,” or even of Allen’s “*Handbook*.” In an age when scholars of the highest character and attainments are criticis-

ing the grounds of Christian authority and belief, how can we hope to commend to the coming physician, even of our own school, such a *Materia Medica* as we now offer him?

It is simple truth to say that homœopathy is up against a wall here, and cannot progress until this obstacle is removed. How shall this be accomplished? All through the century just closed there have been occasional provings of new drugs, and sporadic attempts at re-proving some of the older ones. Quite recently the ophthalmic section of the American Institute has initiated a new crusade of this description, and the preliminary work of organization is under way. I hope it may prove a success, but, as I read the history of previous endeavors of this sort, I must say I fear it will not. It is an undertaking of such magnitude and importance that I do not see how any voluntary association can perform it in such a way as to commend the results it may attain to thoughtful men.

Consider for a moment. How many drugs could it properly handle in a year? Five or six would be a liberal estimate, and to complete the work would require twenty years at least.

Again, there are really few men in our ranks who are competent to conduct a proving as it should be made; so that, with all the professional and social duties that befall the ordinary physician, it does not seem possible to accomplish such a tremendous task in this way.

What, then, can be done? I would suggest that under the patronage of the American Institute a regular college of pathogenesis be established and endowed, where systematic work of this sort could be conducted by paid experts and provers, and thus a genuine *Materia Medica Pura* be compiled under the rigorous rules of modern scientific investigation. To some this scheme may appear Utopian. To me, however, it seems not only feasible, but the only feasible plan.

In these days, when the "gospel of wealth" is so powerfully preached and so brilliantly exemplified by Andrew Carnegie and others, there must be some of our multi-millionaires who can and will appreciate the immense value of a real *Materia Medica Pura*, and who would gladly endow such an institution, if the project were outlined and endorsed by some influential and responsible organization like the American Institute of Homœopathy.

Such endowment need be temporary only—so given as to revert to the donors at the close of a fixed and definite period. And the sale of such a work as could thus be produced would largely repay the interest on a sufficient endowment.

The whole homœopathic world should contribute to such an institution, for but one would be needed, and its work would endure for all time. I believe, too, that such a college would be favored by enlightened physicians of every name, for its object would be simply and only the development of the true relations of drugs to the human system, a knowledge of which relations is and always must be of basic value, irrespective of therapeutic theories or creeds. Certainly, in no way could men of wealth so directly and abundantly benefit mankind. With a *Materia Medica* thus evolved and recorded, the main obstacle to the progress of homœopathy, both as a science and an art, would be removed.

Can we not, as a society, do something to hasten such a medical millennium? At least we can memorialize the Institute, and urge an attempt to realize this ideal. Such an effort—world-wide and enthusiastic—would have a reflex influence upon ourselves. It would consolidate and energize our school, for there is nothing like ambitious strife after high and noble ideals to bind men together, develop what is best in them, and make their labors fruitful. To evolve such a *Materia Medica Pura* is the true mission of the homœopathic school, and its accomplishment would crown that school with undying honor and fame.

A second difficulty in homœopathic prescription arises from the fact that even a *Materia Medica Pura* demands interpretation in the light of physiology and pathology. Hints of what is possible in this direction are to be found in the works of Dunham, Farrington, and others. But the genius who is to expound and interpret pathogenesis, and give to the world a great philosophic *Materia Medica*, has yet to make his advent. I have faith, however, that “in the fulness of time” such a genius will appear. As for ourselves, like John, the forerunner, we can only be criers in the wilderness, looking and longing for the coming of such a medical Messiah.

Other difficulties in homœopathic prescription inhere in and are inseparable from its symptomatic basis. Our patients may be too young, too ignorant, or too sick to describe their sensations fully and clearly.

The physician is compelled to ask leading questions, and the replies are often misleading. If we could credit and utilize clairvoyance in the examination of patients it might be very helpful, but for some reason it is unreliable.

Again, in many forms of disease no dependence whatever can be placed upon symptoms of a subjective nature, however clearly conceived or accurately reported. This is to a large extent true of all reflex maladies, and often also of diseases of the kidneys and heart.

No physician of even ordinary discernment would prescribe for the morning headache, due to chronic nephritis, upon the basis of the sensations in the head or their conditions. So, too, in chronic valvular disease, the symptoms manifested by the heart are often entirely worthless as a basis for prescription. The pathologic status of the heart may be exactly what it has been for ten, twenty or more years. Nature has compensated the valvular deficiency by hypertrophy, and no symptoms are evoked until some other organ, like the liver or lungs or kidneys, is obstructed, and then the heart complains.

What more common, however, than to find the symptomist addressing his remedies to the complaining organ in accord with the sacred "totality" of Hahnemann? Do not misunderstand me, nor hastily decry me as a heretic. I know quite well the value of the "totality," and how, by means of it, we are often able to reach out into the darkness, where pathology stumbles about helplessly, and rescue sufferers who must otherwise be lost. But we must have an intelligent conception of what constitutes the "totality" in each case when we do employ it, as well as apprehend the situations in which reliance upon it is worse than futile.

Still another inherent difficulty appears in the multitude of drugs which act upon certain organs, *e.g.*, the head, the lungs and the bowels. Fully one hundred must be considered in prescribing for a headache, a cough or a diarrhœa.

The average memory staggers under such a task. Even in chronic cases of these varieties how often has flat failure mocked our best and most deliberate efforts. How much more in acute conditions, where time and circumstances combine against us, where the death-angel hovers near, and we must be speedy if we would wrest the victory from him. Then come the old perplexing questions of the dose, the single or alternate remedy,

etc., which still further complicate the task of accurate and intelligent prescription. But these items are too old and worn for discussion here.

Such are some of the difficulties that confront the homœopathic prescriber. And yet, in spite of them all, homœopathy has lived and grown for more than a hundred years. What are its prospects for the twentieth century? It cannot be denied that there is ground for grave apprehension.

As you remember, this topic largely occupied the attention of the jubilee meeting of the State Society in this city. The very fact of such a discussion is significant. If our school were evidently and consciously advancing, no such subject would have found a place upon the program. Most speakers assigned to the discussion either avoided it or "whistled to keep their courage up."

The venerable and honored T. F. Allen alone met the issue squarely, and, as you know, took a pessimistic view which the common herd attributed to his failing health. I cannot so dismiss the incident. If the homœopathic school is advancing, where are the evidences thereof? Are our students increasing in number? Are our journals multiplying? Are conversions to our beliefs and practices as common as they were?

We must move, for to stand still is to retrograde. The world is advancing, and the old school can truthfully boast that it is moving also. It has discovered new and valuable methods of producing local and general anæsthesia, the use of organic extracts, serum-therapy, etc. True these are not exactly along our line, as a school. As has been remarked, the distinctive, characteristic, as well as hereditary, work of our school is the evolution of a genuine *Materia Medica Pura*; and what are we doing in that field to-day?

Ten, twenty, thirty years ago our physicians were, many of them, individual or associate provers, and our journals filled much of their space in recording the results of their self-sacrificing labor. Such labor and such records are rare now, and are becoming still more rare. We rest on our oars as if the journey were ended, ignobly content with our individual ease and profit. This drowsy giant of Homœopathy must arouse from his day-dreams or lag ignominious in the rear of medical progress.

Which shall it be?

THE ANTITOXIN TREATMENT OF DIPHTHERIA.

BY WM. C. GOODNO, M.D., PHILADELPHIA.

(Read before the Massachusetts Homœopathic Medical Society.)

As I have spoken upon the antitoxin treatment of diphtheria before two State Medical Societies, and before the Medical Society of the District of Columbia, and some of you may possibly be acquainted with the fact, it will not be amiss for me to say to you that the address has, in each instance, been delivered in response to a request that I should discuss this subject. It was in each case a sort of "Macedonian cry." For this occasion, however, I was simply requested to prepare a paper. I accepted, and immediately selected for my subject the antitoxin treatment of diphtheria, possibly that I might discuss this subject for once of my own free will, and for the further reason that, marvellous to state, much missionary work must still be done on behalf of this agent. Perhaps I was influenced somewhat by the ease with which I could, in the busy season, prepare a paper upon a subject I have considered so often, but will not commit myself upon this point. I commenced the use of the antitoxin when it first appeared, and have continued to employ it in the treatment of all cases of diphtheria I have since treated.

First, I desire to give you the personal experience upon which my paper is mainly based. To this date I have treated 217 cases of diphtheria by means of subcutaneous injections of the diphtheria antitoxin. All of these cases have been seen in Philadelphia and its suburbs, in private practice, and all have been the patients of other physicians. I have been able to treat this rather large number of cases, under the circumstances, for the reason that comparatively few physicians in Philadelphia employ this agent, and when they do, many send for some one who has experience with it. Fortunately, the number who are personally employing it, and administering it early, is rapidly increasing. It is not an unusual thing now for me to meet a friend for whom I used to treat cases and have him say, somewhat as one did last week, "You have taught me

the trick; I inject my own cases now; I have had 6 cases since I saw you last; all have done well." Of the 217 cases, 9 have died—about 4 per cent. Remembering the 12 to 15 per cent. usually reported as the mortality of this disease under antitoxin treatment, you may be inclined to say to yourselves "This mortality is too small; there must have been many mild cases." But remember, such reports are from hospitals. Any one can get the same result, I repeat, if the cases are treated properly and under similar conditions. Some of you, who feel that you do not get the results you should from the administration of your remedies, chafe when some one wisely says "You did not select the proper remedy." You feel, perhaps, that only to the few is given the peculiar ability and the knowledge to select the right remedy. My worrying brother, here is a disease—a terrible, a deadly disease—for which you can select the right remedy every time. You cannot only select the remedy, but you can employ it, and get a successful result nearly every time. What can you hope for in medicine better than this? Let us work, and pray that the day may soon come when we shall be able, with equal success, to employ an antitoxin for pneumonia and others of the serious acute infections which now claim so many victims. In private practice among the better classes, *i.e.*, people who are well-housed, well-fed, well-clothed, and early attended in sickness, nearly every case of diphtheria should recover. Most of the fatal cases in my series had been ill from four days to a week before receiving the antitoxin, and presented the evidences of intense toxic poisoning. I think it is within reasonable bounds to say that the mortality in private practice should not exceed 5 per cent. The difference in mortality between hospital and private practice indicated is not greater than exists in pneumonia. In attempting to convince the doubters, and those who have not yet formed opinions respecting the value of antitoxin, we are much hindered by certain ignorant, careless statements, such as, "I have practiced medicine for twenty-five or thirty years, and have lost but one case of diphtheria;" or, "I have lost only two or three cases." One who makes such a statement does not know what true diphtheria is, or he has not had the cases to lose, or is carelessly untruthful. Without antitoxin, from one-quarter to one-half, and in certain epidemics two-

thirds, of all cases of diphtheria die, no matter what the treatment may have been, whether allopathic, the crudest homœopathy, well-selected potentized drugs, or the dog-milk kind. We all know that many cases of active diphtheria are controlled by our general methods of treatment, and many of us know all about the exudates which so frequently disappear under the influence of this, that and the other remedy, which are not diphtheria, but which so often pass as that disease. I passed through the stage of great confidence in remedies many years ago. I was sufficiently deceived to think I could cure diphtheria quite regularly, and made permanent my mistake by publishing my conclusions before I had had sufficient experience. After a time I got some diphtheria of malignant type. In spite of my remedies, five died in one family and three in another. I lost eleven in one year when the disease was epidemic. Somehow or other lachesis 30 did not perform its duty when the disease began on the left side, etc. The same result followed the use of other seemingly well-indicated remedies, and Hering, Raue and Guernsey, who advised me, did not enable me to get any better results. Dear old men; how honest, earnest and painstaking they were! Results were not improved by crude methods.

Statistics are not necessary to convince any one of the value of antitoxin in diphtheria. It is simply necessary to employ it a few times properly. It may be stated, however, without fear of successful contradiction, that nothing in therapeutics is as well supported by figures as this antitoxin treatment of diphtheria. Watch the transformation which follows its use in a typical case which comes under treatment rather late—say about the fourth day of the disease. I shall never forget the remarks of my friend, Dr. William K. Brown, over the 'phone one morning. After the customary hello's, he said, "Is it not marvellous?" "What marvellous?" I replied. "The antitoxin," said he; "the membrane is hanging in strings, the temperature dropped four degrees in eight hours, the glandular swelling has already subsided much, and the child wants to eat."

The previous day I had injected a patient of his, three years of age, with the antitoxin. The child had been ill four full days, the exudate was abundant, the throat almost closed by it,

and there was an unusual degree of swelling of the tonsils, uvula, and glands at the angles of the lower jaw. The latter swelling was as great as we meet in a mild case of mumps. The temperature was 104.3° , the child was very drowsy, and the urine scanty and highly albuminous. Convalescence progressed without interruption. This was the first time the doctor had observed the treatment. Any one who has seen such a typical result for the first time must feel impelled to cry out "The day of miracles has returned!" Within an hour I have returned from seeing two cases of diphtheria in consultation with Dr. Neville of Philadelphia. The first, an only child, three years of age, I saw three days since, for the first time. She was then in the fourth day of illness. The exudate had a peculiarly dense, almost cartilaginous appearance. Dr. Middleton, who consulted with us, called the peculiar exudate present "albuminoid." The throat was full of it. Forty-eight hours after the first injection of 3,000 U of Mulford's concentrated serum a membranous cast of the entire soft palate, tough, and one-eighth inch thick, was loosened and readily removed. Only a thin film re-formed, and the child appeared much better in general on the following day. The temperature varied from 100° to 101° and three- or four-tenths. (I like a higher temperature, as it indicates greater power of reaction against the disease.) Then came a day of doubt. The child was drowsy, the temperature lower, the pulse irregular and feeble. What was to be done? Three thousand to six thousand U of the diphtheria antitoxin had been administered daily, and still, after marked improvement, the tide had set against the patient. Believing we were dealing with a mixed infection, we decided to inject at one spot 3,000 U of the concentrated anti-diphtheritic serum, and at another point 10 c.c. of the anti-streptococcic serum. The following day all symptoms were found to have been much relieved, and I believe there has been no subsequent arrest in the improvement. The mother contracted the disease, but one injection of 3,000 U was followed by immediate arrest and rapid disappearance of the symptoms.

More important than any other advice which can be given relative to the practical application of this treatment is, *administer the antitoxin early*, and repeat within six to ten hours if the first injection does not give an easily appreciable improvement.

If we adopt the plan of very early injection of the serum in all cases some non-diphtheritic ones may possibly receive the antitoxin, but I am unaware that any bad results have followed such a mistake. On the contrary, if we delay the injections for any reason whatever, some cases of diphtheria will attain a considerable degree of development before they are effectively attacked, resulting in prolongation of the illness and a higher mortality.

The question, not only of the use of antitoxin, but of its early employment, should be agitated upon every suitable occasion until the profession is perfectly convinced not only of its value, but well acquainted with the details of its administration. The first injection should be given as soon as it is suspected that the case is one of diphtheria. As a rule, it is better not to wait for a bacteriological examination. Upon this point I am not entirely in accord with prevailing practice, as I believe that the clinical evidences of diphtheria should be relied upon in the early stage of the disease rather than a negative bacteriological report. There are several reasons for this. As yet, much of bacteriological work yields imperfect results because of inexperience, carelessness, and the many and great difficulties attending research of this abstruse character. It is not rare to receive a negative report upon a first examination, subsequent cultures demonstrating the presence of the specific organism. It is also possible to fail to discover the Klebs-Löffler bacillus in the secretions of the throat, but to find it in the nasal discharge. These facts alone are sufficient to show that if we are guided in our use of antitoxin by bacteriological evidence only, the institution of the treatment may be at times unwisely delayed. In other words, a single bacteriological examination cannot be accepted as absolutely determining the nature of the case in every instance, and a negative result should not be permitted to overrule the clinical evidence. You will, I hope, not regard these statements as intended to reflect unfavorably upon bacteriology in its relation to diphtheria, for I highly esteem it.

Many objections have been raised against the employment of the diphtheria antitoxin. The contention that it is injurious, or in any degree a disturbing agent, has not been supported by facts. Some little disturbance, especially cutaneous, has very infrequently resulted from its use, especially from the weak

antitoxin first produced, and was probably due to the large quantity of horse serum employed in relation to the number of units, or to certain preservative agents. In all of my cases I have noticed symptoms clearly attributable to the antitoxin but once, viz., an eruption of innocent character beginning at the point of injection. The antitoxin now employed is of such an excellent quality, and contains, in relation to the number of units, such a small quantity of serum, that the question of bad results from its use may be safely dismissed. The statement one so frequently hears respecting its power to cause albuminuria seems to be without foundation. On the contrary, albuminuria is an almost constant attendant upon active diphtheria, and is generally promptly diminished by the administration of antitoxin. Many times I have found the quantity of albumin diminished one-half or two-thirds within twenty-four to forty-eight hours after the first injection. I have also repeatedly examined the urine of immunized persons without once discovering albumin; but in respect to this, it must be confessed that the small number of units usually administered for immunizing might not be sufficient to produce this result. Some homœopaths object to the antitoxin treatment because they think its action is not according to *similia*. While I do not propose to argue that it is, there is certainly much of *similia* in its selection, and of *contraria* in its action, which was at least Dr. Hering's explanation of the selection and action of homœopathic remedies. But even if its action is in no way related to homœopathy, the objection is puerile. As homœopathy displaced other therapeutic systems, it in turn may, especially within limited spheres, be supplanted by more recent methods. There are some persons, however, who would have us believe that therapeutic progress ceased with Hahnemann. What his therapeutics might have been had he lived fifty years longer is past surmising; but one thing is certain: he did not occupy one position very long.

Such feeble objections as that "many of the cases treated with antitoxin are not diphtheria," etc., are scarcely worthy of consideration. It is true that the bacteriological method has enabled us to include some cases which would, if clinical observations only were employed, be excluded; but at most this could affect the mortality percentage but a little. That failures

result from its use no one will dispute, but the failures are in nearly every instance clearly due to a violation of those rules of guidance laid down by every expert who has written upon or taught this treatment. Failure is due to the neglect to begin the treatment until irreparable injury has been done the tissues. Another prominent cause of failure, and one which I do not think has been emphasized, is neglect to continue the antitoxin simply because the pharyngeal exudate is disappearing or has disappeared. The disappearance of the exudate does not, in my opinion, indicate that further injections are unnecessary. I now continue to administer 1,000 U each twenty-four hours, or at least during each forty-eight hours, until the general condition of the patient is entirely satisfactory, regardless of how clear the pharynx may be.

There is no more important fact to be kept in mind than that diphtheria is a mixed infection; and in some cases the accessory, which is usually essentially a streptococcic infection, outruns the Klebs-Löffler infection and becomes the important factor in the case. When this accessory infection develops rapidly it results in the development of those cases which defy the diphtheria antitoxin, and sometimes in a comparatively early stage of the disease. The antistreptococcic serum should be administered to these cases, along with the diphtheria antitoxin. I have called your attention to a case of this kind. While excellent results are occasionally observed as late as a week or more after the initial developments of the disease, we cannot count upon them as probable.

When the diphtheria antitoxin shall be considered more from the standpoint of prophylaxis than as belonging to curative medicine, it will be administered more often in the earliest stages of the disease before the deadly toxins have disorganized the blood, left a necrotic tract in the tissues, and rendered incapable forevermore the sensitive nervous elements which preside over the most delicate and vital functions of the body. He who waits until this stage has no reason to expect favorable results from any treatment. While the antitoxin will save the tissues if early and properly employed, it can never restore a single cell.

My advocacy of the antitoxin treatment is based upon my reading of the ablest clinicians the world over, as well as upon

the ample personal experience referred to. The statistics relating to this subject are so extensive, so convincing, so unanswerable, that I am at a loss to comprehend how the well-informed and unprejudiced man can remain unconvinced. There is not another item of practice in modern therapeutics in support of which such an immense array of real evidence can be marshalled—evidence which will bear the bright light of scientific observation. You cannot bring together a tithe of the same character of evidence in favor of phosphorus as a remedy for pneumonia, of rhus for rheumatism, or of any other remedy for the treatment of any disease-condition known by name, or for any group of symptoms, that we possess in favor of the diphtheria antitoxin as a remedy for diphtheria in its early stage. It is the most brilliant, towering fact of modern applied therapeutics, standing out boldly above every other fact, and which it is easily possible for any one to prove to his entire satisfaction. If this be true, some will ask, Why do a few men, recognized as honest, able and painstaking observers, fail to get results which enable them to give to this treatment their approval, and others oppose it without a trial? In reply I have to say that more than nine out of ten of the recognized clinical authorities of the world give it their unqualified and enthusiastic commendation. Those who have had unsatisfactory results have used it but a few times, and usually imperfectly. Do you know of any other subject in medicine, theology, law, politics or general literature, which can marshal the same per cent. of support? When all good and able men agree respecting the practical value of homœopathy, as to the advisability of free trade or protection, the interpretation of Browning, the merits of the Anglo-Boer war, expansion, or as to whether a gentleman should turn up his trousers or not, we may expect unanimity respecting the value of the diphtheria antitoxin in the treatment of diphtheria, and many other things. Some men have what we might express as a kind of hereditary title to their opinions upon certain subjects. How many of you are homœopaths because you thoroughly investigated therapeutics and determined it to be the superior system? How many of those who antagonize the Homœopathic school know practically anything about it? Scarcely one. No! we are usually this, and that, and the other, because our fathers or friends or

preceptors were. Not one man in a hundred is anything as the result of elaborate, painstaking investigation, the while preserving an unbiased mind. And this is especially true of men who face some great revolutionizing innovation like the antitoxin treatment of diphtheria. Man is partisan or antagonistic by nature (and some of us have a terrible amount of nature); and if he does not possess the hereditary title, so to speak, to properly shape his position, when he begins to think for himself he finds, if fearless in introspection, that growth in partisanship is usually more rapid than growth in knowledge.

In conclusion, I desire to say that I have prepared a short paper, that I might not encroach too much upon your time for discussion. If I have treated my subject in a very general and enthusiastic manner, rather than in a cold, scientific vein, it is for the reason that I am convinced that the antitoxin treatment of diphtheria has passed the experimental stage—that it is a sound, well-established practice, which requires only that it shall be brought forcibly to the attention of those physicians who have as yet employed it improperly or not at all. To any who may consider beginning its use and seek information, I may say that there is much of importance relating to dose, frequency, the care of the syringe, the details of injection, etc., all of which must be mastered in order to a high degree of success. I have treated of these details in other papers; and many recent writers, especially those who treat of children's diseases, go into them fully.

POISONING BY BISMUTH.—Dr. Dreesmann, of Cologne, recently reported before the medical society of that city the case of a man of 30 years who, previously strong and healthy, was burned by flaming alcohol on his left leg and thigh. The fifth day after that he entered the hospital and was treated twice a day, locally, with a 10 per cent. ointment of bismuth subnitrate. Three weeks later it was noticed that his urine would deposit a blackish sediment in the pot de chambre, which was with difficulty removed. Three weeks later he became affected with stomatitis, with violent pains and difficulty in swallowing; a bluish-green line formed along the edge of his gums, and his tongue, the sublingual mucous membrane and soft palate also turned the same color. This gave these parts the appearance as if he had eaten raspberries. After discontinuing the salve these symptoms slowly disappeared; but six months later traces of this pigmentation were yet to be seen.—*Muenchener Medicinische Wochenschrift*, No. 6, 1901.—(I have seen salivation follow large doses of the subnitrate, given internally. The quantity of saliva secreted was enormous.)

EDITORIAL.

MISREPRESENTATION.

THE violent, virulent and aggressive hatred of homœopathy on the part of the editor of the *Philadelphia Medical Journal* was no secret; and when, through circumstances over which he had no control, the editor became an ex-editor, it was also no secret that by personal appeals to the various homœopathic journals, as well as by circulars to the individual physicians, he sought to secure the favor and support of the homœopaths for his new undertaking, *American Medicine*. His promises of fairer and more impartial treatment of homœopathy, if not expressly stated, were at least implied in these appeals. What, then, was our surprise to find, in the number of *American Medicine* for April 13th, a Quotation, without Comment, from *The Homœopathic Envoy for Propagating the True Medical Faith*, April, 1901. It is possible, we know, to damn with faint praise; here we see that we can damn without comment. We doubt whether there would have been any striking dissimilarity between our respective comments had we and the editor of *American Medicine* undertaken to make any on the paragraphs quoted from the *Envoy*. That, however, is not the question; it is the animus which prompts such quotations by the editor which has given rise to our doubt and surprise. Is it an intended evidence of fraternal feeling towards his erring brethren, whose friendship he seemed but a short time ago so willing to conciliate? Is it proof of a desire to deal with them in a fairer and more impartial manner? Or does it show that he considers the homœopaths no longer necessary to the success of his editorial venture, or unwilling to give it their support? Or is his hatred so ingrained that he cannot, with the best will in the world, refrain from seeking to bring ridicule upon anything that bears the name of homœopath? (*Vide Prov. xxvii., 22.*) These were the questions which forced themselves upon us, but

we are obliged to confess that we are unable to discover the underlying motive for these quotations without comment. We would fain hope that it was not an unfriendly one, since all other references to homœopathy which have appeared in his journal up to date have not been open to criticism.

It would be well, in this connection, to draw the attention of the editor and of others at the same time, to the fact that the *Envoy* is in no way, shape or form a representative homœopathic journal. It is, as itself announces, a popular journal, and is marked by all the stigmata of other popular publications. Its very title shows the common arrogance of popular sectarian literature, and it glories in not representing modern but old Hahnemannian homœopathy, thereby ignoring entirely and rejecting all the progress of the last century. What it says, therefore, can be supposed by a fair-minded editor to possess only an antiquarian interest for the readers of his journal, and if the quotations are given with this presupposition, then it will be considered as a harmless joke, a little humor to relieve the seriousness of its surroundings. It is asking too much to expect outsiders to recognize the position held by the *Envoy* and kindred contributions to so-called homœopathic literature. It is difficult to assign them a place in the homœopathy of the present day. In the early history of the school such popular appeals had a necessary and very important place to fill, and even at the present day, in Germany, they have not outlived their usefulness. Here, however, in America, their legitimate sphere of action is and should be exceedingly limited. It can most aptly be compared with that occupied by the Salvation Army in the religious world. That goes marching on, to the beat of its drums and the blare of its horns, with Scripture quotations wherever they can be put, its startling tracts, and its red bands on hats and coats. By such methods, as a living protest against a supposed aristocracy of Christianity, it reaches many outside the pale of the churches by means adapted to its own peculiar end; but no one would be hardy enough or one-sided enough to take its utterances and its acts as representing either the good or the bad of Christianity of the twentieth century.

In the same way the homœopathic literature to which we have reference delights in protesting against the medical sci-

ence of the present day (often falsely so called, as we are most ready to acknowledge), and with many a drum-beat, and tom-tom music and flourish of trumpets, seeks to draw the lay-public, if it cannot reach the educated physician, away from the allurements of medical progress, back to the simplicity of Hahnemannianism,—aided by tracts and quotations galore. With all this, it would seem scarcely necessary to insist that such a paper as the *Envoy* is no exponent of the views of the majority of homœopathic physicians of to-day, although it claims the title “Homœopathic.” That the people should be misled by such a claim is but natural, but that it should have imposed upon the editor of *American Medicine* is passing strange. It will, therefore, no doubt be a source of gratification to him to learn that the quotations offered without comment do not express the ideas of the majority of representative homœopaths. We trust he will be more careful as to the sources whence he collects his knowledge of homœopathy, since, as in the present case, his motives might readily be misunderstood and his readers misled.

Where so important a branch of medical science and art is concerned as in the case of homœopathy, it would seem imperative that all rational physicians should acquire their knowledge of it at first hand, and not be content to judge it from such imperfect and garbled statements as have hitherto appeared in the journals of the old school. We venture to assert that there are but few homœopathic physicians of the present day who are contented with the “gleanings” of progress made by the allopaths as they are found in some homœopathic journals, and that the majority of them read one or more of the original sources. A just and mutually advantageous appreciation of the merits of the schools can only be arrived at by a more thorough acquaintance with their respective literatures; then there will be no danger of exalting the *Envoy* and the hopeful Munyon to the positions of representatives of Homœopathy.

RE-PROVING THE MATERIA MEDICA.

IN the general trend towards specialism, homœopathy as a whole has come to be regarded as itself a specialty in medicine, concerned chiefly with therapeutics, on the basis of a law applicable only through a materia medica constructed on lines peculiar to itself. The peculiar fundamental character of a homœopathic materia medica dare never be lost sight of, since it is indissolubly connected with the application of the homœopathic principle.

It has long been felt that, however correct in principle, the *Materia Medica Pura* of Hahnemann could not meet the demands for a reliable scientific presentation of the effects of drugs on the human organism. The more closely the original provings and day-books have been examined and collated, the more clearly has this appeared. Various efforts have been made to remedy this defect, suggested and undertaken from various points of departure. The attempt to sift the wheat from the chaff according to any fixed arbitrary standard must always prove unsatisfactory and unreliable. From a practical standpoint we have frequently favored and advocated a gradual elimination and a relegation to subordinate places of unreliable symptoms, by means of clinical experiments, for which our hospitals and dispensaries afford ample facilities. We have urged that there would be the place to test the symptoms of our materia medica. Were each specialist in these institutions to make for himself a repertory of the symptoms found in our materia medica concerning his own specialty, and to seek to interpret them, and then to apply them both symptomatically and pathologically, surely a great and speedy improvement of the working materia medica would result.

From a scientific standpoint the re-proving of drugs in some way or other has been frequently advocated with more or less enthusiasm, but the difficulties up to the present time have seemed insurmountable.

At present two plans are placed before the profession, one of which, advocated as the only feasible one, by W. S. Searles, A.M., M.D., of Brooklyn, N. Y., will be found in the present

issue of this journal. He suggests the establishment, under the patronage of the American Institute, of an endowed college of pathogenesy, where systematic work of this sort could be conducted by paid experts and provers, and thus a genuine *Materia Medica Pura* be compiled under the rigorous rules of modern scientific investigation. For the full details and advantages of this plan we refer to the paper itself.

A second plan was proposed and elaborated by H. P. Bellows, M.S., M.D., of Boston, in his presidential address before the American Homœopathic Ophthalmological, Otological and Laryngological Society at Washington, D. C., in June, 1900, and entitled, *The Re-proving of the Homœopathic Materia Medica from the Standpoint of a Specialist*. He says: "The principal objects to be attained by such re-proving are, in the main, a greater discrimination and accuracy in both the observation and the description of whatever drug-effects may be developed; a more perfect elimination of all sources of error in confusing drug-effects with constitutional disturbances or temporary derangements of health from other causes; a restoration of the natural sequence or grouping of drug-effects as indicated in different organs and tissues of the body; and, as the result of all this, the presentation of a definite, precise, sharply-defined statement of the pathogenic sphere and mode of action of each remedy studied." In order to do this the laboratory method of research must be employed, and this can only be done by trained specialists covering the fields of the mind and nervous system, the eye, the ear, the nose and throat, the chest, the genito-urinary system, and the skin; that arrangements should be made for the assistance at all times of laboratory experts for chemical, microscopical, bacteriological and physiological tests; that the provers should be subjected to careful preliminary organic and functional tests; that they should receive compensation for their time and services, the means to come from private sources, from funds administered by our medical colleges, or from the treasuries of our State societies; that stringent regulations and control should be adopted to avoid deceit and self-deception; that daily records be submitted to the director of the provings, to be by him examined, tested, amplified or verified, as the case may demand; and that, finally, the results of the provings as a whole be summarized and arranged for

publication in scientific form by the director, with such aid from any or all of his associates as he may desire.

This plan has met with the recognition which it deserves, and the society to which it was presented appointed Dr. Bellows General Director, who in his turn appointed, as a committee to carry out an experimental proving, two or more members in each of the following cities: New York, Brooklyn, Chicago, Philadelphia, St. Louis, Boston, Baltimore, Cincinnati, Buffalo, Cleveland, Detroit, Washington and San Francisco. The members in each of these cities form a sub-committee, with a chairman who acts as Director of Proving for his city—all under the supervision of the Director General.

This is surely a very plausible and apparently practicable scheme, and all will await its outcome with intense interest. The main objection, and that a very serious one, is the length of time which must necessarily be consumed in obtaining the proving of even one remedy. Whether this can be obviated in any way it will now rest with the workers to show. The two principles involved must be regarded as correct—the necessity of re-proving, and its best accomplishment through specialists. The way in which this is to be brought about is all that distinguishes the plan of Dr. Searle from that of Dr. Bellows. In the former, the obstacle is lack of money; in the latter, lack of time; but, since time is money here in America, there may appear a way, some time in the future, of reconciling the two plans practically, as can now be done syllogistically.

ELECTION METHODS.

MANUFACTURERS of fire- and burglar-proof safes recognize the fact that they cannot produce an article which the ingenuity of the cracksman cannot overcome. Hence they rest content with making an article which will give the burglar the greatest difficulty in opening. No laws or rules can do away with offensive political methods, hence we must rest satisfied with such laws as reduce intrigue and sinister methods to a minimum. Medical societies the world over have many of their advantages nullified by political activity and methods which interfere sadly

with the scientific business of the sessions, and this is true of the American Institute of Homœopathy as of other medical organizations. To obviate the evils complained of, the present by-law, which provides that candidates for the individual offices shall be named by nomination papers was adopted, not as an ideal method, but as calculated to produce the best results under existing circumstances. That it has several distinct advantages we are free to admit, but we doubt very much if it is capable of giving the best results, as shown by the character of men elected or by the lessening of pernicious political activity.

Section 7 of Article IX. of the by-laws provides that the nominations shall be made at the first morning session. The election shall take place at the second morning session. If no nominations are made for any one office, it is the duty of the Executive Committee to see that at least one paper shall be prepared for each of the elective officers. The early date thus provided for the nominations makes election matters the first duty of more than one member as soon as he reaches the meeting place. To act intelligently, it is necessary that the various candidates be carefully studied prior to the opening of the sessions. What are the possible evils of this election system? Active political work begins long before the time of the Institute meeting. This is a necessity; for if those actuated by the best motives withhold their efforts until they arrive on the ground, they will find others, possibly less patriotic, fully organized for the campaign, and therefore invincible. The early hour at which the nominations are made necessarily excludes the possibility of nominating men whose special fitness for the office and the demands of the hour are demonstrated during the proceedings. It is furthermore impossible for those who have the best interests of the Institute at heart to confer, study the strength and weaknesses of candidates, and present one whose attainments are up to the high standard of the office. It is true that, according to the conditions of the by-law, the president may delay the moment at which he shall declare the nominations closed, although one infers that it is his duty to announce them as closed as soon as the secretary has presented all the nomination papers filed. If the present election system is continued, the phraseology of Section 7, Article IX., should be made more explicit. The lamentable lack of interest in the

vice-presidencies tends to neglect of nomination papers being filed for these offices, and thus the executive committee has the power to instal any candidate at its sweet will, oblivious of the fact that a vice-presidency is but too often regarded as a stepping-stone to the higher office.

The advantages of the system are found, first, in the saving of time. Members can attend business and scientific discussions while the election is in progress. No time is wasted in nomination speeches, etc. The second advantage is that the voting privilege is limited to members who have paid their annual dues to date, and this adds to the financial prosperity of the Institute.

The old system provided that nominations should be made in open meeting, following which the members proceeded to vote. At first it was customary to accompany each nomination with speeches eulogizing the candidate. As long as such speeches were kept within bounds, no objection was offered to the practice; but it was abused, and became offensive to some members and innocently amusing to others. We must confess ourselves to have been amused by these political rhetorical pyrotechnics. Inasmuch as they never defamed any one, and only demonstrated the very many virtues of the candidates, they were harmless, excepting as wasters of valuable time. The oratorical powers of the nominators oftentimes obscured their logic, and thus misled the members in preparing their ballots. Finally, nominating speeches were abolished. Candidates were named, and the election proceeded. But this system was not popular, and it was displaced by the one now in vogue.

Can any better system than those thus far tried be adopted? In the American Medical Association it is customary for the nominations to be made by a nominating committee. These nominations are equivalent to an election. Will a nominating committee be satisfactory? A nominating committee can discuss with amazing frankness the fitness of candidates. If an ideal one could be obtained to do the work, we believe that it would solve the problem. Experience has thus far failed to demonstrate that it will do so. The great difficulty is in obtaining the properly constituted committee. If a majority of its members will act unselfishly and intelligently, the results will

be excellent. The members of an association are only too ready to regard the actions of such a committee with suspicion. They are only too prone to charge sinister methods to the appointing power. It is not wise to have such a committee named by the president or any other one man. That officer may be actuated by the highest possible motives; nevertheless, he will be liable to the accusation of appointing a committee that will surely produce a result in keeping with his wishes. In other words, he practically names his successor in office. It has been suggested that the committee be composed of one or two members from each State. Then the question arises, "How shall they be selected?" We might let the delegations from each State make the selections; or we might constitute the members who have attended the largest number of sessions as the State representatives. This latter plan is open to the objection of making the nominating committee consist of nearly the same individuals year after year.

The nominations having been made, how shall we elect? We might accept the report of the committee and make the nominees our officers. We might vote as we do at present, if more than one set of candidates are presented. Or we might vote by postal card! ? But who shall count the ballots? In order to vote by postal card, it will be essential that we modify our by-laws. The vote by postal card is fascinating to some minds, but we do not think it a good practice, because the voting privilege should be limited to those who appreciate it sufficiently to attend the meetings. Certain States having the largest membership would shape the results of the election to favor certain portions of the country with a regularity that would not be advantageous to the association. It is true that the postal-card system might start an interest in the Institute among some who stay away with monotonous regularity. But we believe that "what is worth having, is worth coming for," and the election privileges in the Institute should not be held too lightly. As matters are at present, there are members who make it a point to be on hand on election day at least, if the demands of their practices will permit them to stay no longer. We do not wish to hint that they are politicians. On the contrary, they are determined that the Institute shall be well-officered if their efforts are successful.

In closing, we must confess ourselves undecided as to the best course under the circumstances. We believe that the present system, if continued, should undergo important modifications. If a new system is adopted, or if we return to one of the old, the details should be enrolled upon the by-laws with greater clearness than we find in present Section 7, Article IX. We do say that some change is necessary. Members complain that the proper business of the session is hampered by the wire-pulling and axe-grinding. Is it so? To listen to some men, we would infer it was an omnipresent nuisance. Listening to others, we regard it as evidence of the active interest taken by the members at large in the government of their national association.

AMUSEMENTS AND SCIENCE.

THERE lies before us a notice sent out by a committee of citizens of Richfield Springs, tabulating the plans already arranged for the entertainment of the members of the Institute and their families during the week of June 15-22, 1901. The programme is unquestionably a most fascinating one, including about everything possible, from a Beethoven symphony to a vaudeville performance, for the entertainment of the guests. In fact, we believe that never before was such an elaborate programme planned for any medical society. Individual members may have fared more sumptuously at other gatherings, but here all hands are to be fairly lionized. Now, we have no objection to this as long as it does not interfere with the sessions, were it not for the motives behind this generosity. The programme very candidly states that two thousand dollars have been raised by subscription. "The citizens and property owners of Richfield Springs realize the power of physicians in advertising a health resort such as Richfield Springs is, hence the desire to please your honorable body."

In other words, we have been invited to Richfield to advertise it. The entertainment is offered for a consideration.

Personally, we believe that we will be well entertained; we believe that we will be cared for as we have never been before. There being a selfish interest involved, this is a matter of course.

We believe that there will be a large and interesting meeting. Such of the scientific programme as has been brought to our notice shows that the proceedings will not be lacking in instruction. We therefore urge upon all the members to attend, and make the gathering an even larger one than that of Atlantic City two years ago.

But we do not like to be used for advertising purposes.

A CONTRIBUTION TO THE STUDY OF FATTY INFILTRATION OF THE HEART SECONDARY TO SUBPERICARDIAL "OVERFATNESS."—*Fatty infiltration*, as met with in cases of extreme obesity, differs very much from *fatty overgrowth* of the heart (fat around the heart). Fat heart is divided (*a*) *fatty overgrowth*, (*b*) *fatty infiltration*. By the former is meant a deposit of fat around the heart, or it can be called subpericardial fat. The latter refers to the fat dipping between the muscular fibres. Clinically a distinction is also made between the two varieties.

(1) *Fatty Overgrowth*.—This represents by far the greatest number of cases and is easy of recognition. There is a large amount of fat deposited beneath the pericardium which may in a mechanical manner produce respiratory and circulatory disturbances, particularly venous stasis, cyanosis, small pulse, dyspnoea, or an asthmatic attack and sometimes cough. These symptoms are brought on by undue exercise. The venous stasis leads to a passive catarrh of mucous membranes. The renal output is deficient and there is a condition of lithæmia resulting. The heart's action may be suddenly arrested as a result of exercise. There are two forms of pulse found in this condition: (*a*) *Plethoric*, which is full and tense, and as a rule regular; (*b*) *Anæmic*, which is less tense, increased in frequency and regular.

(2) *Fatty Infiltration*.—This is secondary to the anæmic form of obesity. The renal output is markedly deficient. In most instances the fatty infiltration reaches its greatest development in the right ventricle, the left being rarely completely involved.

The deposits are most marked near the surface. The infiltration exerts pressure on and between the fasciculi, producing atrophy and embarrassing the action of the heart.

Perhaps the first symptom noted is a beginning dilatation as the result of some strain. Urgent dyspnoea, præcordial discomfort, pain under the sternum, attacks of angina pectoris, arrhythmic pulse and collapse. Slight arrhythmia is not indicative of fatty infiltration, but the marked and the constant are strongly suggestive of that condition. There may be present even a *delirium cordis*.

As to the heart sounds, the second one is feeble, thus enabling one to differentiate fatty overgrowth which has the first sound enfeebled. Basal systolic murmurs are at times heard, due in all probability to the irregular contraction of the muscle fibre. They may be hæmic in origin, but they are not the result of valvulitis. Spontaneous rupture of the heart has been noticed.—*Amer. Journ. Med. Sciences.*

GLEANINGS.

SPINAL ANÆSTHESIA BY CATAPHORESIS.—Since the introduction of spinal anæsthesia into Surgery, perhaps the most desirable object to accomplish is to make the anæsthetic penetrate the membranes without puncturing them, and this is suggested in the use of cataphoresis. A tube electrode having a ball on the end, and through which passes a smaller tube which can be attached to a hypodermic syringe, is introduced between the spinous processes of the third and fourth lumbar vertebra. It is introduced until the bulb is stopped by the ligamentum subflavum; then the inner tube is thrust forward just far enough to pierce it and yet leave the dura untouched. The syringe is then attached and anæsthetic is introduced. The inner tube is then withdrawn, and the positive pole is attached to the larger tube and the negative sponge is applied over the abdomen. The cataphoric action resulting will cause the fluid to penetrate the membranes.

One test of this procedure was tried and with some gratifying results, although the operation was not a signal success. The author puts forward his idea in the hope that it will be taken up and investigated.—*N. Y. Med. Journ.*

William F. Baker, A.M., M.D.

ABDOMINAL PAIN IN TYPHOID FEVER.—The group of cases in which pain was present during the whole course of the disease may be divided into several classes, viz.:

1. Pain due to associated conditions, as hysteria, lung conditions, bladder, abortion, labor, menstruation.
2. Conditions of the gastro-intestinal tract apart from complications, including food, vomiting, constipation and diarrhœa.
3. Abdominal conditions apart from the specific bowel lesions, including appendicitis, peritonitis, cholecystitis, abscess of the liver, painful spleen and phlebitis.
4. Specific intestinal complications, hæmorrhage and perforation. Pain is perhaps the most constant and valuable symptom of perforation. It may be of sudden onset, or it may be more long-lasting. An attack of pain of sudden onset and referred to the penis is very suggestive of perforation. The pain may be paroxysmal, and after the paroxysm the patient may seem comfortable.—*N. Y. Med. Journ.*

William F. Baker, A.M., M.D.

THE CARBOHYDRATES OF THE URINE IN DIABETES INSIPIDUS.—Besides the well-known excretion of glucose in pathological quantities, there is a marked increase in the fermentable carbohydrates. The conclusions reached are that diabetes can no longer be looked upon as pure "*glucose disease*," but it is rather a disturbance of the carbohydrate metabolism in general.

The method of examination used was the precipitation of the carbohydrates

by *benzol chloride* in the presence of *sodium hydrate*. They come down as benzo-esters. The filtrate can be collected and weighed after being washed and dried over sulphuric acid.

The questions raised from the experiments are: (1) Are the carbohydrates still excreted in large amounts in diabetes mellitus when the glucose excretion has disappeared under the influence of diet? (2) Are they increased? and in some cases it looks as though they were.

If an increase could be shown in a large per cent. of cases of diabetes insipidus, it might indicate an interesting relation between this and diabetes mellitus. It is probable that the constant flushing of the kidney may carry large amounts of carbohydrates into the urine, for the increase and the decrease of diuresis does show, according to the table presented, an increase or decrease in the amount of carbohydrates.—*Amer. Journ. of Medical Sciences*, May, 1901.

William F. Baker, A.M., M.D.

STEREOAGNOSIS AND ALLIED CONDITIONS.—Stereoaagnosis is defined to be the faculty of recognizing objects, their nature and use by contact in handling them. Astereoaagnosis is the inability to so recognize objects. The ability to recognize objects is not a sense. It cannot be classified with the touch, temperature or any other sense. It is a perception or the combining of many sensations, and from this combination the forming of a conclusion as to what the object really is.

The inability to do this may be due to the fact that the "patient may have lost the tactile mental images and have nothing with which to compare the images received." Or the trouble may be in the grouping together of the many sensations received. The failure of one of the forms of sensation may result in this condition.

The senses concerned in the recognition of an object by contact are (a) *tactile*, (b) *pressure*, (c) *localizing sense*, (d) *muscular sense*.

There may be an inability to recognize objects by handling them without any disturbance of the sensation.

The conclusions reached from several clinical cases are:

1. The ability to recognize objects by handling them will depend on the integrity of the afferent nerves, cortical sensory area, and cortical perceptive area, and disease in either will make it impossible to recognize objects handled.

2. There is a distinct area in the cortex in which sensations produced by handling objects are grouped together to form tactile memory image. This tactile perceptive area is in the parietal lobe. It is not the same as the sensory area, although it may be located within the boundaries.

3. It would be well to limit the term stereoaagnosis to cases in which the inability to recognize objects by contact is due to some failure of sensation caused by brain disease either in the cortical sensory area itself or in the fibres going to it.

4. In the cerebral palsies of children when there is an inability to recognize objects in the paralyzed hand, the tactile memory images were never acquired.—*Amer. Journ. Med. Sciences*.

William F. Baker, A.M., M.D.

TREATMENT OF ROUND WORMS.—Dr. Deguy, in the attempt to expel the oxyuris, which seems so easy and yet in practice meets with so many failures,

advises both local and internal treatment. Not only are the rectum and large intestines the habitat of these worms, but they also live in the lower portion of the small bowel. The simplest treatment is to purge the child with a dose of calomel according to its age, and put it on a milk diet for twenty-four hours, to free the bowel of fecal matters. Then for two days give santonin, 0.50, one dose in the morning on an empty stomach, or cina (wormseed), 3.0. Infuse it in 100 gms. of boiling water and add 20 gms. of some syrup.

This simple treatment in three days will have evacuated the intestine of the parasites, except the females, which are liable to live in the rectum. Hence a local measure is necessary, for vermifuges do not easily reach that portion of the bowel. One of the following enemas may be employed: Tansy, 2.0; water, 200.0; glycerine, 20.0. Infuse the leaves in the water and add the glycerine later. Or menthol, 0.25; oil, 60.0. A third formula is: Santonine, 0.50; infuse in water, 150.0. Another efficacious and preferable method is to empty the rectum and to follow that with a solution of nitrate of silver, 1:200; have the child hold it for five minutes, and, after it has been passed, neutralize the excess by an injection of salt water. This method rarely fails. It requires four days, however.—*Journal des Praticiens*, No. 8, 1901. —(It is well to know something about the life-history of the commoner varieties of worms. Their treatment requires something more than handing a patient a few tablets of santonine and calomel.)

Frank H. Pritchard, M.D.

MARRIAGE OF TUBERCULOUS SUBJECTS.—Prof. C. Gerhardt, admitting the difference of opinion among the authorities on the subject of the marriage of consumptives, attempts to study the question. He points out the greater danger to the female on account of the exhausting drains from pregnancy, parturition and suckling, which may awaken an apparently cured tuberculosis. He has seen a young physician who had had consumption and had been well for several years, but who married and who died of disease which was thereby fanned into activity. A year after his death his wife, formerly a healthy girl, died of the same disease, and the next year their only child, of meningeal tuberculosis. Tuberculosis may be transmitted directly through the genital organs, yet this is rare, for opportunities for infection through the organs of respiration are common enough. Gerhardt holds that marriage has a weakening influence not only on the wife, but also on the husband. He has often seen an astonishingly favorable action from induced abortion in tuberculous women, but he warns against its misuse. He sets forth the general rule that consumptives should have been well at least a year before being permitted to marry. To control the increased sexual appetite, an important measure, he has seen good results from lupulin and camphor, and above all from digitalin, given in the evening, in doses of $\frac{1}{16}$ th to 1 mgm. This increased sexual irritability is probably the cause of tuberculous patients becoming so often infected with gonorrhœa or syphilis. In general, his views are pessimistic.

In the discussion of this paper, which was read before the Berlin Medical Society, Fürbringer cited Cornet, showing that out of six hundred marriages among consumptives, in 23 per cent. an infection of one by the other party could be demonstrated. Cornet has seen young consumptives go rapidly to pieces after marrying. Fürbringer has, however, seen cases where consumptives who looked miserable yet improved perceptibly after marriage. v. Leyden was also more optimistic, though in general he agreed with Ger-

hardt. As a rule one cannot prevent consumptives from marrying; therefore, one should not paint the consequences in too dark colors. He is not in the habit of advising against matrimony if the symptoms are not too far advanced. The outlook for the children is not altogether gloomy, for he knows of several couples who have had children who have remained well. Practicing physicians should not form a judgment after too dogmatic principles. He has also seen a few examples of tuberculous infection from sexual intercourse amongst single persons.—*Hospitalstüdende*, No. 5, 1901.—(Prof. Peter, of Paris, was in the habit of saying that a tuberculous woman might bear one child, possibly two, but never three. Another French writer states such a woman should not marry; if she should, not bear children; if she should give birth to one, not nurse it.)

Frank H. Pritchard, M.D.

ON THE ACTION OF SUPRARENAL EXTRACT.—Fresh solutions of dried suprarenal glands may be introduced into the conjunctival cul-de-sac without producing any irritation. It has been found that the conjunctival vessels contract and disappear from view first, but if the action of the material be continued sufficiently long, the scleral vessels will do the same. This renders the drug of considerable service in inflammatory and congestive disturbances of the ocular structures. It has been found that probably the most marked therapeutic action which may be noticed is the ability of the gland material to quiet certain intractable cases of glaucoma, particularly if it be used in connection with weak solutions of some of the older myotics.

Darier's formula, which contains three centigrammes of chlorohydrate of pilocarpine and two centigrammes of salicylate of eserine to ten grammes of an equal part solution of dried suprarenal glands in water has given him the best results.—Zimmerman, Stuttgart, *La Clinique Ophthalmologique*.

William Spencer, M.D.

THE EXTRAOCULAR COMPLICATIONS OF SYMPATHETIC OPHTHALMIA.—Rogman removed a cataract from the left eye of a man 59 years of age by the combined method. At the end of two weeks' time the wound had healed and the eye was quiet. There were, however, a few fibres of the iris caught in the wound. A fortnight later the eye operated upon became irritated. The aqueous humor was cloudy and there was a diminution of visual acuity. Despite energetic treatment the intraocular infection increased and was followed by a sympathetic uveitis. This ran a course of alternating improvement and aggravation. In about three months after the performance of the operation the patient became suddenly deaf. This condition was not attended by any pain. There were not any apoplectiform manifestations; neither was there any lesion of the external or the middle ear. The patient remained blind and deaf until the date of his death, which was caused by uræmia. The author attributes the loss of hearing to an inflammatory process starting at the base of the cranium and extending along the auditory nerve until it possibly reached the labyrinths.—Rogman, Grand, *La Clinique Ophthalmologique*.

William Spencer, M.D.

OCULAR TUBERCULOSIS AND ITS TREATMENT.—Galezowski, of Paris, in a brief article devoted to this subject, mentions the following forms under which this disease has come under his notice: Engorgement of the lachrymal gland, tubercles of the iris, tubercular choroiditis and optic perineuritis. He classes

the cases reported as tubercular conjunctivitis as being doubtful. Tubercle of the iris he considers may be confounded with gummata, but the fact that they are small and scattered over the organ will usually serve to differentiate them from the larger, generally single, syphilitic manifestations, even when the latter are unaccompanied with keratitis and a cloudy, vitreous humor. Nevertheless, he says, the surgeon should search for tubercular foci in other portions of the body in order to make his diagnosis certain.

Tubercular choroiditis, he believes, is a more common affection than is generally supposed, the author seeing one or two cases every year. Tubercular perineuritis may be provoked by tubercles of the brain, or a tubercular meningitis. It resembles closely the optic neuritis accompanying other brain tumors and other forms of meningitis, except that it appears as a diffuse, incomplete perineuritis, which develops slowly.

Treatment, he says, should be constitutional, while operative measures should be postponed as long as possible.—*Recueil d' Ophthalmologie*.

William Spencer, M.D.

THE REFRACTING OPTICIAN.—Every man can instance many examples where harm has been done by the pseudo-profession of opticians. A case, reported elsewhere, recently occurred in this city. A mother, at the instance of a teacher, took her son, a lad of 8 or 10, to one of these fakirs, with the history of dullness in school and poor vision. Unable to improve the visual acuity of the boy by any glasses, he jumped at the conclusion that there was some cerebral trouble, and telling the mother that there was inflammation of the optic nerve, advised her, not, as one would suppose, to see a physician, but, instead, to give the boy some strychnia. She obtained from a druggist some tablets containing one-sixtieth of a grain of strychnia and proceeded to feed the boy upon them, thinking that the prescriber was a doctor and that he would not advise her to do anything that was harmful to the boy. As a result, convulsions occurred and a dangerous termination was only averted by a timely knowledge of the treatment he was undergoing. The vision was easily improved by proper lenses and no further trouble was experienced.

A lad with a vision of one-fiftieth was wearing concave spherical glasses of 12 diopters, with no improvement of vision, while his refraction was hypermetropic and required for correction a convex glass of 9 diopters, a difference of 21 diopters. A man recently came to the Rhode Island Hospital with a diagnosis of inflammation of the optic nerves; another with a detached retina for an operation for cataract; a lady recently had her glasses changed four times in as many months, with a steady impairment of vision, who was suffering from albuminuric retinitis, and who died within a few weeks after the diagnosis was made and the condition ascertained; and so example after example might be quoted where injury to the patient resulted both by incorrect adaptation of lenses and failure to recognize existing morbid processes. This is not, however, a plea for special legislation, but an appeal to the profession of this State to discourage the practice of consulting incompetent men for ocular defects.

There is no selfish or pecuniary consideration to this question; on the contrary, every one of the dozens of incompetent men who are doing this work are manufacturing future patients for the physician; but the welfare of the community demands that the profession take a decided stand on this question.

They have it in their power to control this evil within at least moderate bounds.—*The Providence Medical Journal*.

William Spencer, M.D.

THE KNEE-JERK IN CHOREA.—Gordon notes a peculiar modification of the knee-jerk in chorea, which, although it has attracted no attention, has some value in the diagnosis of doubtful cases. With the patient recumbent, if one raises the heel to rest on the couch, making sure that all the muscles are relaxed for the time being, and if one then tests the knee-jerk in the usual way, the foot is found to rise more or less smartly; but, instead of falling back in the usual way immediately, it remains suspended for a variable time—hung up, as it were—and then slowly sinks back to its usual position. This is not present in every case, nor constantly present in the same case; but when present it is, he thinks, peculiar to this disease. There are also variations. Sometimes there is merely a sluggish descent following a normal ascent; sometimes an ordinary knee-jerk is obtained, but just as the foot is beginning to fall again it is caught in mid-air and held for a time, or even raised to a higher level, and sometimes the knee-jerk passes at once into an active, more or less persistent rigid extension of the limb.—*Brit. Med. Journ.*, March 30, 1901.

F. Mortimer Lawrence, M.D.

THE MEDICAL TREATMENT OF TUBERCULOUS PERITONITIS.—Yeo, of London, in a clinical lecture, calls attention to three successive cases of tuberculous peritonitis which received medical treatment. He quotes the gloomy prognoses of Watson, Bristowe and Dieulafoy, by all of whom death is considered the rule and cure but a possibility, and then notes that under modern treatment fully 50 per cent. of the cases recover. He disagrees with the teaching that the peritoneal infection is always secondary, showing by Osler's statistics that 30 per cent. of the cases are primary, and directs attention to infected milk as a probable cause. In regard to the treatment, it was practically the same in all of the three cases which he records—iodine or iodoform applied freely and persistently to the abdominal surface, as well as given internally. The usual method was to order a mixture of equal parts of iodoform ointment and cod-liver oil, to be rubbed in freely over the abdominal surface twice daily, and as soon as pain and diarrhœa had been controlled by bismuth and opiates, to administer internally, three times a day, a pill containing a quarter of a grain of iodoform and half a minim of creosote. The patients were all desperately ill, and yet all made good, though somewhat gradual, recoveries. All were more or less acute cases, two of them markedly so, and they were in young people between ten and twenty years of age. He has seen this method fail in chronic cases of the dry adhesive type and in older persons; and it is in these cases that surgery also fails frequently.

In conclusion, he reviews the successful uses of iodoform inunctions in tuberculous meningitis, and recalls the fact that iodine has long been thought by physicians to be an antidote to tubercle.—*Lancet*, March 16, 1901.

F. Mortimer Lawrence, M.D.

SODIUM SALICYLATE IN DIABETES.—Williamson, of Manchester, has endeavored to ascertain whether sodium salicylate has any definite influence on the sugar excretion in glycosuria and diabetes. Long ago this drug was strongly recommended by Ebstein, and about ten years ago the writer tried it

carefully, but in small doses, and was unable to detect any definite diminution in the sugar. At that time the patients often stated that they felt better when taking sodium salicylate than when other drugs were given. Recently he has prescribed the drug in large doses (75 to 80 grs. daily), and has been able to keep records of the sugar excretion in twenty cases. In one case which he records in detail, dietetic and other conditions remained unchanged; when the drug was given in large doses sugar excretion greatly diminished, increasing rapidly on its discontinuance and again diminishing when it was resumed. Details of the nineteen other cases are omitted. The author concludes that sodium salicylate is not a specific for diabetes. It produces no marked diminution of sugar secretion in the severe forms of the disease, and has little influence on some mild cases. In certain mild cases, however, its action is very marked. Fairly large doses of the natural preparation should be given in doses of 10 grs. three and then four times a day, and increased slowly up to 15 grs. four or five times a day, watching carefully for any toxic symptoms. In severe forms, though sodium salicylate does not usually cause much change in the sugar excretion, the patients sometimes gain weight and improve in general condition while taking the drug.—*Brit. Med. Journ.*, March 30, 1901.

F. Mortimer Lawrence, M.D.

THE PROGNOSIS OF TOBACCO-HEART.—Mitchell Bruce, in his recent Lettsonian lecture, touches upon the anginal and other symptoms of smoker's heart. The prognosis, he says, is comparatively favorable. All the cases which he has had an opportunity to watch did well, provided the cause of their distress was avoided and the heart and vessels were otherwise healthy. Further, improvement begins early, and it may be rapid and recovery complete; but recurrence attends resumption of the habit. Some of its votaries, however, contrive to continue to smoke just short of inducing serious discomfort. Unless a successful effort at reform be made, cardiac trouble continues indefinitely; but even then he cannot say that he has seen serious damage done by tobacco alone in sound hearts, nor arterial sclerosis, as has been stated by some authorities.—*Brit. Med. Jour.*, April 6, 1901.

F. Mortimer Lawrence, M.D.

THE CAUSE AND TREATMENT OF PROFUSE EPISTAXIS IN ELDERLY PEOPLE.—Coates relates the histories of five cases of epistaxis coming on without apparent cause in adults aged upwards of 50 years, and shows that, in all, the sequence of events which led up to the hæmorrhage was essentially the same, namely:

(a). Long-continued high arterial pressure.

(b). Some sudden cardiac failure. In three cases the epistaxis arose from the giving way of a valve, in the other two from loss of power in the heart-wall.

(c). Overfilling of the whole venous system, the weakened heart not being able to sufficiently empty the engorged veins against the high pressure in the arterial system due to contracted arterioles.

(d). Leakage from an overfilled vein.

The most satisfactory treatment of these, as well as other forms of passive venous hæmorrhage, is to empty the overfilled veins. As long as they are enormously distended with blood the hæmorrhage must continue unless direct mechanical means are used, and if one nostril be plugged the epistaxis is apt

to start from the other. If, on the other hand, we can relax the walls of the arteries and help the enfeebled heart to do its work, it will soon empty the overfilled veins. But, as a rule, this cannot be done by giving heart tonics at first, and the immediate treatment must be directed to the small arteries, where the real cause of the epistaxis lies. Nitroglycerine is quite effective, nitrite of amyl might be more so; and afterwards one of the more slowly acting drugs, as erythrol tetranitrate, or even thyroid extract, might do as well. When capillaries and arterioles are dilated and pervious comes the time for strychnine or strophanthus.—*Lancet*, April 20, 1901.

F. Mortimer Lawrence, M.D.

THE PROTOZOON OF CANCER.—Gaylord, in offering a preliminary report based upon three years' work in the New York State Pathological Laboratory, remarks that others have found organisms in cancer and have explained them as protozoa, but all observers have noted the great variability of these forms in the tissues. The latter has been due, he asserts, to the fact that ordinary staining methods are unreliable for such research, for by working with fresh methods the organisms can always be found. These bodies resemble fat in the fresh state, but by applying the ether and the osmic-acid tests it is found that they are not fatty; and it has been discovered that their edges can be cracked with the cover-glass.

His first experiment was undertaken with peritoneal fluid withdrawn aseptically from the abdomen of a patient suffering with an adeno-carcinoma originating in the appendix. This fluid, which remained bacteriologically sterile after thirteen days' incubation, contained a large number of small hyaline bodies which were observed under the microscope to increase in size and change their form and pass through a cycle of development to what appeared to be a spore-forming stage. This fluid was injected into the peritoneal cavity of a dog and a guinea-pig, and into the jugular of another guinea-pig. The animals inoculated in the peritoneal cavity developed only marked peritonitis and lymphatic enlargement, but in the peritoneal fluid were detected characteristic bodies corresponding to those previously discovered in the primary case. Section of the lung of the animal injected in the jugular showed, after fifty days, beginning foci of adeno-carcinoma, and in the perivascular lymph spaces many half-grown organisms were detected by Plimmer's staining method, the latter corresponding to those described by him as occurring constantly in carcinoma in man.

Following this experiment attention was directed to fresh scrapings of cancer, in which the organisms were found to be present in great numbers, and fluid from the centre of carcinomata which had undergone degeneration, the so-called cancer milk of the older writers, was discovered to consist practically of a pure culture of these organisms. Extended observation proved that *all the organs, including the blood, taken from all regions of all cases dying of cancer, including sarcoma and epithelioma, contain large numbers of these organisms.* Moreover, in all cases of carcinoma and sarcoma thus far examined in which cachexia was well marked, the organisms, especially the younger forms, can be detected in the peripheral blood.

After reviewing the investigations as to the possible relation of the yeast organism to cancer, and concluding that they have nothing to do with each other, Gaylord details the staining method by which Plimmer was able to

demonstrate parasitic bodies in 1130 out of 1278 cancers, and states that his observations completely substantiate Plimmer's claim that these bodies are present in all carcinomata. This organism is apparently, he concludes, a protozoön belonging in the same group with the vaccine organism.

As the result of inoculating a number of guinea-pigs, rabbits and dogs with materials derived from sarcomata and carcinomata, fresh examinations of the peritoneal fluid, the organs and the blood, invariably demonstrated large numbers of the parasites. Two guinea-pigs and two rabbits, inoculated in the jugular with peritoneal fluid, developed beginning adeno-carcinomata of the lung, thus confirming the result of the first experiment. In addition, one guinea-pig presented a primary carcinoma of lungs and liver, and one dog a lymphoma of the spleen. The tumor cells in all contained the characteristic parasite.—*American Journal of the Medical Sciences*, May, 1901.

F. Mortimer Lawrence, M.D.

THE CAUSE OF CANCER—A CRITICISM.—Cullen, of Baltimore, remarks that in order to prove conclusively that a given organism is the cause of cancer it is necessary :

- (1) To find or isolate the organism.
- (2) To produce cancer by inoculating the organism into another body.
- (3) To recover the organism from the cancer thus produced.

It is certain that the nodules produced by Gaylord in the guinea pigs' lungs are cancer ; but he used peritoneal fluid and not a pure culture of the organism, and hence the first and second requisites are not properly fulfilled. He cannot exclude the possibility that cancer-cells, which may be transplanted and grow, may have been contained in the fluid. He speaks of being able to cultivate his germ with "comparative regularity," and yet no word as to its appearance or behavior on the culture medium is offered, nor, apparently, was a pure culture used for injection into a single animal. As a matter of fact, Gaylord has confirmed the results of others, but added little or nothing new, and the cause of cancer is still unknown. It is very unfortunate that the suggestion that cancer parasites are floating around in the blood leads many to the inference that, since cancer is a blood disease, removal of the growth is useless. This is certainly erroneous ; that it is permanently curable in the early stages by removal of the growth has been proven by hospital results, both in Europe and America.—*American Medicine*, May 18, 1901.

F. Mortimer Lawrence, M.D.

THE ANTISEPTIC AND SERUM TREATMENT OF PERNICIOUS ANÆMIA.—

Before the Royal Medical and Chirurgical Society, Hunter exhibited a man, aged 37 years, whose symptoms—breathlessness, palpitation and progressively increasing weakness—had come on very gradually two years before. There was constant pain in the stomach and mouth, with exacerbations about every three weeks, after which the mouth and tongue became very sore ; gastric pain, nausea and retching were worse when the stomach was empty. A curious tingling and numbness of the fingers were complained of occasionally, and there was a history of oral sepsis extending over ten years. On admission, there were four groups of symptoms, viz. :

(1) Weakness and extreme anæmia and their usual effects ; the red corpuscles were only 27 per cent. of the normal and hemoglobin only 35 per cent. ; there was also poikilocytosis ;

(2) Hemolytic symptoms, viz., urobilinuria and lemon color of the skin ;

(3) Oral and gastro-intestinal symptoms, viz., sore tongue, dental necrosis, suppuration of the gums at one part (which had existed for ten years), and gastric pains; and

(4) Toxic symptoms, viz., tingling and numbness of the fingers and irregular pyrexia.

The treatment consisted of oral and gastric antiseptics, the teeth were scraped, some were extracted, and a mouth-wash was used. Mercuric chloride was administered constantly. At intervals of a few days three injections of antistreptococcic serum were given, and in the course of three weeks the red corpuscles rose to 65 per cent., the hemoglobin to 72 per cent., the hemolysis (as evidenced by the color of the urine) was arrested, and the patient's health slightly improved. Later, liquor arsenicalis was added to the treatment, and the patient was sent into the country for a time; and now the patient had gained in weight, his blood count was normal, and the only symptom remaining was occasional numbness of the fingers.

The case, Dr. Hunter remarked, must be regarded as a typical one of pernicious anæmia in its mode of onset and clinical history and the four groups of symptoms present. The results clearly showed the beneficial results of serum treatment, at the same time confirming the infective nature of the disease.—*Lancet*, March 30, 1901.

F. Mortimer Lawrence, M.D.

TWO CASES OF CONJUNCTIVITIS VACCINALIS.—The first case was a child of two and a half years, who had been recently vaccinated, and who since that time had been fretful and feverish. When seen the arm was very much swollen, and a typical vaccination sore was present. She had been inoculated on the right arm. The right eye was closed, and there was an abundant secretion between the lids. The upper lid was enormously swollen, hard, and overlapped the lower lid. On everting the upper lid there was to be seen about 3 mm. from the free border, and right in the middle of the lid, and situated in the conjunctiva, a vesicle the size of a pea, which when opened showed an ulcer coated with a bloody purulent material and rather shallow, and having a rather hard, mottled base.

This effervescence was quite isolated, and there was nothing like it anywhere else about the eye. The bulbar conjunctiva was very chemotic, but not much reddened. The cornea was normal. The conjunctiva of the lower lid was swollen and red. The condition remained unchanged for two or three days and then commenced to improve, and in ten days had disappeared, leaving scarcely a trace. The treatment consisted in cooling applications, irrigations with mild sublimate solutions and the application of a sublimate salve.

The second case was also a child, four years of age, who had been recently vaccinated, and whose arm presented the characteristic sore. The right eye was the one which was affected in this case, and its condition did not materially differ from the eye in the first case except that the vesicle was more angry looking and more suggestive of its probable origin. The condition got well with the same treatment as was followed in the other case.

The author then discusses the probability of its being due to a different kind of infection, and having no connection whatever with the vaccination, such, for instance, as herpes, either of venereal or tuberculous origin. He thinks, however, that the source of the infection is pretty clearly established. He alludes to the fact that there are only six cases in literature which are

exactly similar to his case.—Dr. A. Pihl, Göthenburg (Sweden). *Klinische Monatsbl. für Augenheilk.*

William Spencer, M.D.

THE TREATMENT OF INFECTED PERFORATING WOUNDS OF THE EYEBALL.—The author, who has made his observations in the clinic of Prof. Everbush, has come to the conclusion that the so-called conservative treatment of this class of injuries deserves wider acceptance or approval than is usually given it. He mentions a number of cases which under the old *régime* would have been treated by enucleation, but which, treated under the new system originated by Prof. Everbusch about ten years ago, resulted in the preservation of the eyeball.

The method to which he especially calls our attention is that where the galvano-cautery is used, the treatment is as follows: The point is heated to a red heat and is applied to the cornea, gently passing through the latter, layer by layer, till the anterior chamber is reached and a small stream of aqueous flows out. It makes no difference whether hypopion is present; the method is indicated except that any active evacuation of the contents of the anterior chamber should be omitted. If the corneal wound is linear and lengthwise the peripheral end of the wound should be selected for the cauterization, and if there are several small wounds the application should be made to the most convenient spot. The conjunctival cul-de-sac should always be flushed with a physiological salt solution and a compress bandage applied. If there is any pain, an ice-bag should be applied over the bandage. If the inflammatory symptoms increase after this measure, and hypopion shows itself again, the paracentesis should be repeated in two or three days. The author then reports three very striking cases in which this method was employed. In all three cases the wounds may be classed as desperate, and the results may be regarded as satisfactory, so far as a shapely eyeball was concerned.

The paracentesis with the galvano-cautery owes its value to several factors. The fistulous opening which is established allows the inflammatory and infectious matter which is in suspension in the aqueous to flow out, such, for instance, as the fibrin, the exudates and precipitates, all of which are undoubtedly irritating and infectious in character. This filtering process is going on all the time, and the eye is thereby relieved of much that is distinctly hurtful.

Another useful factor in the production of good is the lowering of intra-ocular tension, and as the tension is lowered we know that fresh and pure blood pours into the coats of the eye, and through this condition alone better circulation and metabolism are brought about.—E. Glauning, Erlangen (*Münch. Med. Wochenschr.*).

William Spencer, M.D.

THE FACE AND PUPIL IN ALCOHOLIC NEURITIS.—In the course of a short article bearing the above-mentioned title, the writer calls attention to the following pupillary signs:

Another point is the condition of the pupil reflex, which is just the reverse of the Argyll-Robertson phenomenon. In a number of cases of alcoholic neuritis I have noticed that the reflex of the pupil to light is rapid and extensive, whereas the contraction of the pupil on accommodation to a near object is slight and sluggish, or entirely wanting. Indeed, in one or two cases I have observed a dilatation instead of contraction on accommodation.—T. Lauder Brunton, *The Lancet*.

William Spencer, M.D.

CHRONIC PURPURA IN ARTERIO-SCLEROSIS OR ANGIO-SCLEROSIS.—Dr. Gaucher, touching on a form of chronic purpura in those with arterio-sclerosis affecting the lower extremities, called attention at a recent meeting of the Société des Hôpitaux, of Paris, to a case of this eruption extending over the whole body, although it began twenty years ago, and only a year ago did it become generalized. At present the macules are brownish and itch greatly, which is aggravated by the heat of the bed. The whole skin is covered with reddish-violet and varicose venules, which on rupturing give rise to these purpuric spots, subcutaneous hæmorrhages. While in the hospital an eruption was noticed. At first vividly red, the patches became paler, to turn yellowish-brown. The sclerotic state of these smaller bloodvessels favored their rupture. During the discussion Dr. Barié stated that several years before he had observed an arterio-sclerotic who, with a double aortic lesion, for five years had had chronic purpuric blotches on the dorsa of both feet as well as on the anterior-external portions of both legs.—*La Semaine Médicale*, No. 19, 1901. (I have often noticed these spots on the *hands* of old persons with contracted kidneys. An old Irish woman described them to me as "dead nips," for according to her they are caused by ghosts or spirits biting a person during sleep. "Ghost bites" is another quaint name. That calls to one's mind the numerous legends of the vampires or ghosts that prey on sleeping persons. This belief is widespread among the Slavic nations. It is amongst races Slavonic by tongue as well as descent that the genuine vampire tales flourish most luxuriantly: in Russia, in Poland, in Servia, the Czechs and Slovaks of Bohemia. Among the Scandinavians, and especially in Iceland, they were the cause of many fears, though they were not supposed to be impelled by a thirst for blood as in Slavic countries. "The Story of Grettir the Strong," translated by E. Magnusson and W. Morris from the Icelandic, will make a shudder run over one.)

Frank H. Pritchard, M.D.

PNEUMONIA SIMULATING APPENDICITIS.—Dr. Mirande has collected eight cases of pneumonia, of which six were lobar, in which the symptoms at first pointed wholly towards the appendix as the seat of inflammation. During the first three or four days there were repeated chills, fever, vomiting and pain which were decidedly localized in the right iliac fossa, and even in cases where the disease later affected the left lung. The "symptom-picture" may be even in adults so classical that one does not harbor a doubt but that one has to do with an appendicitis. The lung symptoms are so much in the background that no one would suspect pneumonia to be present. In some of his cases an operation disclosed a wholly normal appendix. These sources of error will be especially noticeable in children, but in the course of three or four days the case will clear up; the abdominal symptoms retrogress and those of the lungs become more prominent.—*Hospitalstidende*, No. 15, 1901. (Children often complain of a pain in the belly, and even in the right iliac fossa, in a lobar pneumonia. But by careful examination and watching the case one soon gets a clear idea. It is by being satisfied with a few symptoms, and not by looking for physical signs, that one is easily led into a mistake.)

Frank H. Pritchard, M.D.

A CASE OF BASEDOW'S DISEASE WITHOUT A VISIBLE GOITRE.—Dr. Goris observed a young girl of 15 years who suffered from a feeling of continual oppression at the lower portion of the throat. Her respiration was

difficult, her pulse rapid, and she had palpitation of the heart. Laryngoscopic examination showed the trachea to be flattened and pushed backwards, so that the opening was very narrow and sabre-shaped. Though no tumor was to be felt or seen, it was assumed that a retrosternal goitre was at the bottom of the trouble; and indeed such a growth was found and removed, with a complete recovery following.—*Münchener Medicinische Wochenschrift*. No. 16, 1901. (I once observed a girl of 9 years, who suffered from palpitation and tachycardia, with wide-open and staring eyes and a noticeable degree of pallor. At that time no goitre could be found, though one developed later. There was a systolic murmur at each cardiac valve, which was in a great measure hæmic, "a blood-murmur." Treatment had been directed to this sign, and the case diagnosed as "heart disease." We all, like the Seven Blind Men of Hindustan, it must be confessed, are too ready to get a hold on the elephant's tail, trunk, or tusk, and think that that is the whole elephant. *Semper dubitare*.)

Frank H. Pritchard, M.D.

HEMATEMESIS FROM VARICES OF THE (ESOPHAGUS, STOMACH OR DUODENUM).—Dr. A. Cohn warns us against jumping to a diagnosis of carcinoma or ulcer of the stomach, etc., as soon as a patient is seen who vomits blood or passes it with his fæces, for it may be due to enlarged veins in the œsophagus, stomach or duodenum. They are by no means rare, and are to be observed at any age. They are often associated with cirrhosis of the liver, which may escape recognition if there is no ascites, and the icterus is very slight. The history of the case, spirit-drinking, and the enlarged spleen may be the only things to hang a diagnosis on. And not only that, the hæmorrhages may be copious and frequent. Thrombosis of the various large veins of the abdomen may bring about these two signs—hæmatemesis and melæna. He cites in support of this the case of a woman who vomited blood after thrombosis of the splenic vein during child-bed; the necropsy confirmed this. Other cases demonstrate a general disease of the abdominal veins without appreciable cause. All these patients will tell one that the blood was vomited suddenly, without forerunning dyspeptic symptoms or other prodromes. These hæmorrhages are usually very frequent and profuse, but the patient soon gets up after them. The symptoms of cancer and ulcer are lacking. Of course it is best not to attempt to push a sound down such a patient's throat. In short, try to exclude hepatic cirrhosis above all things, first.—*Rivista Critica di Clinica Medica*, No. 6, 1901.

Frank H. Pritchard, M.D.

IDIOPATHIC PIGMENTED SARCOMA OF THE SKIN.—Dr. R. Bernhardt reports two cases of the fusiform-celled variety of this peculiar skin disease. The first was a man of 52 years, whose disease began as an erythema on the back of his left hand, followed by the development of nodes. On entering, his whole body was covered with spots with or without nodes, the largest being of the size of a cherry. Some had softened down and had been absorbed; there were no ulcerations. Microscopically, two varieties of cells were noted—the fusiform and the ovular.

The second case was that of a man of 51 years, who, four years before, had first noticed a steel-bluish pigmentation of the dorsa of his feet, which, later, was complicated by infiltrations and nodosities, which rendered walking diffi-

cult on account of pains in his heels. The feet, especially the left one, the tibio-astragalar joints, the pharyngeal mucous membrane, the posterior of the right faucial pillar, presented a slight node; on the hard palate there were two dark patches. The pathological changes were the same as in the preceding case. A similar diagnosis was made.—*Przegląd Chirurgiczny*, Zeszyt 4, 1901.

Frank H. Pritchard, M.D.

LIVER IN NIGHT-BLINDNESS.—Dr. W. J. Buchanan states that in India, where nyctalopia is not at all uncommon after malaria or scurvy, the native physicians have a peculiar method of treating it. They advise the patient to eat, for several days in succession, of the livers of sheep, oxen or goats, fried in oil. In two to three days an improvement is usually noticed, and in a week a cure generally follows. Out of twenty cases treated in this manner he did not see a failure.—*Münchener Medicinische Wochenschrift*, No. 15, 1901.

Frank H. Pritchard, M.D.

POISONING BY A BELLADONNA PLASTER.—Dr. W. M. Jones applied a belladonna plaster to the chest of a girl of 21 years, at 11 o'clock in the morning. At 9 in the evening he was called and found her greatly excited, her pupils dilated to their full extent, they did not react to light; there were dryness of the mouth, nausea, and irritation of the bladder, itching of the skin and erythematous swelling of her fingers. After removing the plaster the skin was found swollen and of a scarlet-red color. Under proper treatment she soon recovered. The plaster was analyzed and found to contain 0.02 atropine.—*Ibidem*.

Frank H. Pritchard, M.D.

A NAIL IN THE RIGHT BRONCHUS FOR TWO MONTHS; DIAGNOSIS BY THE X-RAYS; REMOVAL BY MEANS OF AN ELECTRO-MAGNET.—Drs. Garrel and Gouilloud observed a child of 18 months who had gotten a nail into his throat, which slipped down into the right lung. Two months later, by skiagraphy, it was located in the right bronchus. After previous tracheotomy an electro-magnet was thrust into the tracheal wound, and at the first attempt, "à la stupéfaction de tous," it shot up and clung to the magnet. It measured 53 mms. in length. By a combination of Killian's method of bronchoscopy and the electro-magnet, it may become possible to remove iron and steel objects from the respiratory passages without a capital operation.—*Annales des Maladies des Oreille*, etc., No. 1, 1901.

Frank H. Pritchard, M.D.

THE QUANTITY OF NIGHT AND DAY URINE.—Dr. Laspeyres states that a healthy adult excretes more urine in the day than during the night. If one reckon the day urine as 100, and that of the night as 50-60, it still may change to 80:90 as to day and night urine, and this relation be physiological. A day is reckoned from 6 A.M. to 9 P.M. In diseases of the circulatory apparatus, as arterio-sclerosis, myocarditis, valvular lesions and kidney affections, the normal relation may be so altered that more urine is excreted at night than during the day, at times much more. The more serious and irreparable the disease of the circulation, the more urine is passed at night. This was especially observed in myocarditis and arterio-sclerosis, while in acute nephritis and in nervous heart affections there was no change. In health, the less urine is formed at night on account of decreased metabolism during sleep and rest. When, on the contrary, the organs of circulation are weak and diseased, they cannot work off the fluid which has been taken up during the day, and a portion of it is retained in the tissues without any actual œdema result-

ing, and is excreted at night, when the calls on the tissues are less, and no food either solid or fluid is taken.—*Hospitalstidende*, No. 13, 1901.

Frank H. Pritchard, M.D.

VENOUS THROMBOSIS AFTER TYPHOID FEVER.—Dr. E. Schwartz, of Vienna, had under treatment a boy of 14 years, who several years before had had typhoid fever, followed by an œdema of the legs, which rapidly disappeared from the left, but persisted in the right leg. At present there is a plexus of veins which are well developed on the outer side of the whole right lower extremity, one part of which connects with the internal mammary through the epigastric vein, while another portion is lost in the lumbar region. He therefore thinks this state to have been due to a thrombosis of the right iliac vein, after typhoid fever.—*La Semaine Médicale*, No. 14, 1901.—(I once saw a case of what was diagnosed retrospectively as an obliteration of the inferior vena cava. The patient, a boy of about 16 years, presented a network of tortuous veins which, numerous, thick and irregularly coursing, were plainly visible over his legs and the lower portion of his belly up to the diaphragm. On one leg he had an obstinate patch of eczema, which was healing under antiseptic treatment and strapping. His health was otherwise quite good.)

Frank H. Pritchard, M.D.

A CASE OF ARGYRIA.—Prof. v. Jaksch observed a workman who for fourteen years had been manufacturing “perles” of glass, filling them by sucking a mixture of nitrate of silver, ammonia and caustic potash into them by means of a tube. Naturally, some of this fluid would get into his mouth, yet it is only during the last four years that he had noticed the characteristic grayish discoloration of the skin. This was most noticeable in his face, least on the lower extremities, while his genitals were free from pigmentation. Though the mucous membranes were pigmented, his hair was normal.—*Münchener Medicinische Wochenschrift*, No. 14, 1901.

Frank H. Pritchard, M.D.

THE PERMANENT RESULTS OF OPERATIONS FOR FIBROID TUMORS OF THE UTERUS.—(Schenk.)—The question has been raised as to the importance of leaving one or both ovaries, if healthy, after removal of the uterus. Zweifel is of opinion that, considering Abel's report, not only should the ovaries be left, but that, when practicable, the stump of the cervix should be made large enough to preserve a small piece of endometrium. Abel's examinations have shown that removal of the corpus uteri causes atrophy of the ovaries, so that in three years after removal of the uterus the patients suffer from the same symptoms as those who are castrated. In three women, in whom a small piece of endometrium and the ovaries were left, the menses continued in a slight degree and the functions of the ovaries were preserved without the climacteric symptoms above noted. The cervical stump in such cases never has given any trouble.

The question of carcinoma developing in the stump of the cervix after supravaginal amputation is of some importance. This occurred once in a series of seventy-four cases. Jacobs reported two cases, Welmer and Menge reported a case of sarcoma developing in a cervical stump. Savor has reported four cases from the Vienna clinic of carcinoma, and has heard of one other. v. Erlach has reported another case, but is not sure that malignant disease was not present in the corpus uteri when it was removed. Freund has had one similar case. In other words, there are known to be twelve cases

in literature in which malignant degeneration developed in the stump of the cervix after removal of the corpus uteri. These cases are so few in comparison with the very large number of operations that the writer agrees with Sanger that so long as supravaginal myohysterectomy shows so much better results than total abdominal extirpation (4.1 : 9.6 per cent., Hoffmeier), the possibility of malignant degeneration of the cervix later is unimportant as an argument for total extirpation of the uterus. The cervix can be removed afterwards if necessary. Climacteric symptoms have not been troublesome except in a few cases, and in two of these the ovaries had been left. Only 2 patients out of 74 were not satisfied with the results of the operation. Fifty-two of the patients covered periods of ten months to eight years and a quarter after the operation, and letters were received from them reporting their condition.

Forty-one of these had no symptoms; in 6, the symptoms previous to operation were partially or not relieved, and in 3 there was a hernia.

Twenty-seven were fully able to work, and 12 to a less degree.

Thirty-four had increased in weight, 6 very much, and 9 had lost flesh.

In 20 out of 52 cases there were no climacteric symptoms.

Sanger advises delay in operating in the acute stage of most forms of infectious and purulent disease of the pelvic organs, especially when severe peritoneal symptoms are present, and so long as there is any prospect whatever that the inflammation will subside and the pus be absorbed. It is especially desirable, in recent cases of gonorrheal salpingitis or pelvic peritonitis, that the operation be delayed as long as there is the least possibility of diminution of the inflammation with relative recovery, or in some cases a chronic pyosalpinx with sterile pus without a tendency to increase in size, but rather a general shrinkage without subjective symptoms, or after rupture and free escape of pus from single cavities, if the site of perforation does not close and retain the pus.

The direct danger in extirpation of these tumors (pyosalpinx) is remarkably small, but the permanent results leave much to be desired. Only about one-half of those operated on recovered absolutely free from pain and were healthy, and many of the younger women suffered severely from climacteric symptoms.—*Archiv fur Gynaekologie*, Bd. 62, H. 3, 1901.

George R. Southwick, M.D.

VERSION AND EXTRACTION IN CONTRACTED PELVIS.—Wolff.—The results of version and extraction for the infants depend directly on the following conditions:

1. If the membranes are still intact, or just ruptured when the cervix uteri is fully dilated.

2. If the os at the time of version is or is not sufficiently dilated to extract the child as soon as version is completed.

3. If the conjugata vera is more or less than 8 c.m.

If version has been performed very soon after rupture of the membranes and the conjugata vera is 8 c.m. or over, the following factors are important, *i.e.*, the larger the pelvis and the conjugata vera the better, and a pluripara who has had two or three children offers a better prognosis than a primipara. The favorable results of version and extraction are shown by the fact that in fifty-eight deliveries 98.3 per cent. of the children were delivered alive.—*Archiv fur Gynaekologie*, Bd. 62, H. 3, 1901.

George R. Southwick, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

CLINIC AT SAINT-JACQUES HOSPITAL, PARIS, DR. PIÈRE JOUSSET ATTENDING.—CASE I. *Acute Articular Rheumatism*.—Young woman, age 28, entered hospital on the 5th January, 1901. Patient was suffering already four weeks from articular rheumatism. Most of the articulations were affected, the large as well as the small ones, the finger-joints inclusive. Very profuse and acid sweats; fever remittent in character. Temperature normal in the morning, $100\frac{2}{3}$ in the evening.

R. *Mercurius corrosivus*, third dilution, three drops in 200 grams of water, to be taken a tablespoonful every two hours. This remedy is not indicated as an anti-rheumatic, but the profuse sweats and the nocturnal aggravation of the pains justified its use. Patient felt better already on the second day, and cure was complete in a fortnight. After the fifth day of patient's admittance to the hospital, and when the fever attained its maximum, a difficulty in patient's respiration was noticed; there was no evidence of murmur on auscultation, only a lower pitch in the bruits could be detected. *Cactus* θ three drops was prescribed for three days, and the threatening endocarditis disappeared. Why did we not give salicylate of soda? First, because it was not indicated, and second, we clinically know, and the statistics clearly show, that although the pains and the fever may rapidly subside under the administration of salicylate of soda, almost always after forty-eight hours the patient seems apparently cured, but this is only an apparent relief, and not a cure, because, should the remedy be suspended, even seven or eight hours after the subsidence of the symptoms, the arthritis and the fever will recur with the same intensity as at the very onset; the duration of the disease is not shortened with salicylate, deaths due to complications and chronic cardiac affections are certainly at least as frequent after treatment with this drug, while with our indicated remedy, mercurius in this case, our patient was permanently cured without any consecutive affection.

CASE II. *Facial Erysipelas*.—Lady, age 30, of strong constitution, entered hospital on the 26th January. The objective symptoms were: face swollen, eyelids œdematous, ears red and shining, only the chin seems not affected. Temperature in the evening $104\frac{2}{3}$. Next day in the morning temperature $101\frac{2}{3}$, and $104\frac{2}{3}$ at night. R. *China* θ , 5 grams; aqua, 200 grams. Sig. One tablespoonful every two hours. Next morning temperature $100\frac{2}{3}$, in the evening $102\frac{1}{3}$. On the 29th defervescence. Temperature morning and evening normal; the face is much less swollen, and a few scales appear on the affected parts.

Cure progressed rapidly from that day on, the same remedy was continued at a dose of thirty drops only per day, for five or six days. Patient was fed,

and convalescence followed without any complication. For more than thirty years I have treated idiopathic erysipelas with tincture of china in large doses, and I can assure you I have met very many extremely grave cases. I am not speaking of those cases of erysipelas of the face, though very intense, having involved the scalp and produced delirium, because this form as intense as it may be, it always ends in cure, when inappropriate treatment did not interfere in nature's benevolent work; but I mean in the form known as *ambulant*, in which circumstance *china* was always the successful drug. In the allopathic school Jaccoud speaks in one of his clinics of the treatment of erysipelas of the face by the "wine of quinquina," one tablespoonful every hour, and he affirms never having lost a case. Professor Jaccoud attributes the success to the presence of alcohol. This is certainly as poor an explanation as it contains words. What is the matter with the quinine?

CASE III. *Chronic Aortitis*.—Man, age 52, clerk; entered at hospital on the 19th December, 1900. Father was gouty and mother died of cancer. This patient, as a sequelæ of the war of 1870, suffered from arthritis, probably of a gouty origin, and left him with some cardiac palpitations. The actual condition is four years' standing. A very marked dyspnœa, occurring at night after meals, worse from motion, and especially ascending stairs, were the prodromal symptoms. Patient continued to attend to his daily work, but for about eighteen months œdema of the lower extremities compelled him to an absolute rest. On his admittance at the hospital we found him suffering from a constant dyspnœa, with violent crises, brought on by motion, and becoming worse in the recumbent posture. There is a marked œdema of the lower extremities; urine passed in small quantities, and contains a slight degree of albumin, from 0.50 to 1 grm. per liter. The pulse is weak and irregular; auscultation reveals a very marked rasping sound over the aortic region; patient coughs at times, with quite violent spells; there is no lesion in the lungs.

R. Iodide of sodium \varnothing , 30 gr. per day. Breathing soon becomes freer, can lie down, and urine increases in quantity from 900 to 2 liters in twenty-four hours; with this œdema subsides. On the 8th January, 1901, the effect of the iodide seems to diminish. I put him under sulphate of sparteine \varnothing , gr. .05 per day. This remedy is continued until the end of the month; patient feels much better, no shortness of breath, and sleeps well. Iodide of sodium is again administered like before. Patient passes 3 liters of urine per day and is doing well.

After eight days I prescribe antimonium arsenicosum, gr. .25, of the first trituration, per day. Amelioration is further marked, and the patient leaves the hospital on the 12th February. Chronic aortitis, brought to the attention of practitioners through the works of J. P. Tessier as early as 1855, and whose clinical history has been completed by Huchard, is a well-known disease at the present time, and practitioners no longer treat the patients affected with chronic aortitis with iron and quinquina, considering it to be due to anæmia.

According to the general advice, iodide of potassium, and, better still, iodide of sodium, constitutes the remedy best adapted in the treatment of arterio-sclerosis, and hence in aortitis, which is one of the localizations. Doses should vary with each case. Usually I prescribe 1.50 grms. of iodide of sodium in 200 gms. of water, a teaspoonful morning and evening, in half

a glass of hot milk. This should be continued for years, with intervals of a week or two of rest after each potion finished. This will check the disease, and will put patients in a satisfactory condition. But when there are grave symptoms of angina pectoris, or a great disturbance in the circulation, stronger doses should be given.—*L'Art Medical*, March 1901.

John Arschagouni, M.D.

HEPAR SULPH. IN HAY FEVER AND ALLIED CONDITIONS OF HYPER-ÆSTHESIA.—The *Pacific Coast Journal of Homœopathy* for April, 1901, is to be congratulated upon presenting to its readers another of F. F. Laird's most interesting papers (we were going to say "inspirations," nevertheless Dr. Laird certainly has caught the true spirit of Homœopathy). We cannot give, in detail, the arguments by which the author gradually makes the homœopathicity of the remedy to hay fever very plain, but we can promise anyone, who will get the article, a treat in reading it. *Hepar* has been so long linked with croup and suppuration that, to the majority of physicians, its more neurotic side has rested in the shadow. As a remedy for hay fever it is not even mentioned in any of the standard text-books. Nevertheless, continues Dr. Laird, "*Hepar* and naphthalin have been my sheet-anchors in the disease, the former covering far more cases than the latter. As a prophylactic its practical usefulness surpasses that of any other drug; while, in the fully developed disease, a prescription based upon its characteristic symptoms (notice that) brings comfort out of misery. No drug will promptly stamp out the malady in one season; but the writer has repeatedly conquered the tendency to recurrence by faithfully administering *hepar* during three consecutive years, beginning the treatment each year two weeks in advance of the expected attack."

Much more may be learned from this paper. For instance, we are told that it should occupy the foremost rank in the treatment of chronic urticaria. "Itching without visible eruption." Itching over the entire body when undressing, in patients who have irritable skins, easily chafed. Soreness and rawness and smarting on mucous surface of the labia (if a woman) or between the scrotum and thigh, if a man, accompanied by intense pruritus on walking. This is a clinical picture quickly cured by *hepar*.

Again, it is a curative remedy in that protean and comparatively rare affection, angelo-neurotic œdema. In the chronic variety, the sensitive skin, the aggravation from cold and relief from warmth has twice led the author to the successful use of *hepar*.

O. S. Haines, M.D.

AVENA AND ARNICA AS NERVINE TONICS.—Dr. Goullon in the *Leipziger Pop. Z. f. Hom.*, April, 1901, makes some very interesting remarks about the power which these two drugs possess of reviving the vital forces when sinking from disease, overwork, mental emotions or other depressing causes. This observation is of some practical utility, if the results obtained by Dr. Goullon can be duplicated by subsequent trials. The method of giving these remedies may not appeal to all homœopaths, nevertheless the observation is unique and interesting. The author believes that the *avena* tincture contains some wholesome principle which acts in a manner similar to china, wine, cola, etc. He would give to a convalescent patient, who feels prostrated and utterly wretched, and who is slow in making a recovery from his illness, a dose of *avena* three or four times a day. (This *avena sativa* is a tincture made

from the common oats. He mixes 10 drops of this tincture in a wineglassful of water and orders a "sip" at a dose.) Dr. Goullon claims for arnica this same restorative power; and, moreover, he startles us by saying that we will obtain still better effects should we administer both remedies, either simultaneously or in alternation. Thus he would prefer to give 4 drops of the avena with 2 drops of the arnica in hot water. This mixture he claims is far more effective than wine, or even the various restorative wines, sometimes used during convalescence.—*The Homœopathic Recorder*. (We agree with Dr. Goullon that this could hardly be called homœopathic treatment.)

O. S. Haines, M.D.

TREATMENT OF GRIP.—Dr. Walter Sands Mills, of New York, gives us a *résumé* of his experience with "la grippe," during the past winter, in the *Medical Century* for last month. He orders his grip patients to bed, isolates them as far as practicable, puts them upon a light diet, but withholds stimulants. The remedies that he has found most useful were:

Belladonna.—Third cent. dilution in water. This remedy aborted several promising cases. It is indicated by the flushed face, bright shining eyes, full pulse and high temperature. *Bell. must not be given too long*, else it will aggravate the fever. (It is just as necessary to stop your remedy at the right time as it is to start it at the right time.)

Gelsemium.—The use of this remedy was restricted to those patients who felt hot and cold by turns; chilly when moved, even though warmly covered; running at the eyes and nose. The first cent. dilution was used.

Bryonia.—The most serviceable remedy at the beginning of those cases having rheumatic pains in various parts of the body, and also pleuritic pains.

Kali Bichromicum.—The third decimal trituration was prescribed for the coughs following the acute stage. The characteristic cough was paroxysmal, either without expectoration or with the well-known tenacious sputa.

Phosphorus.—30th cent. dilution was prescribed for those patients who complained of rawness of the throat and chest. There was also hoarseness or loss of voice.

Arsenicum Album.—This remedy was the author's most reliable remedy for the nagging coughs, the continued weakness, and so on of the later stages. He also uses this remedy in the third cent., in tablet form.

We commend this *résumé* as an illustration of the clean, discriminating practice of a real homœopath.

O. S. Haines, M.D.

HOW TO CURE WHOOPING-COUGH IN TEN DAYS.—They have been having an epidemic of pertussis out in Illinois the past winter, and Dr. J. K. Eberle, of Pana, writing in the *Medical Visitor* for May, makes some remarkable statements regarding the efficacy of *castanea vesca* in that troublesome affection. This remedy is a tincture made from the leaves of the common chestnut, gathered during the summer, and Dr. Eberle prefers to give it in the 3x dilution upon No. 30 pellets. He has used the remedy "with great success" for the past eighteen years, and says that it loosens the cough and shortens the paroxysms until, by the tenth day, "you would not know that the child ever had an attack of whooping-cough," unless, of course, there are complications. We heard a gentleman, whose four children had

just recovered from a four months' siege of pertussis, remark recently that "he thought children would be better off without the visits of a physician during an attack of whooping-cough, and that he was quite sure their parents would." To those who have had poor success with pertussis, Dr. Eberle's suggestion may be very welcome. We have tried almost all the vaunted "*specifics*" for whooping-cough, and believe that in the future we shall rely upon the homœopathic remedy most closely indicated by the symptoms of each case. Experience has shown us that we cannot improve upon this method at present.

O. S. Haines, M.D.

HOW TO AVOID GOUT, EVEN IF HEREDITARILY PREDISPOSED TO IT.—

Dr. James Searson (England) seems to have a very strong conviction that no one *need* have gout, whether they have a predisposition to it or not. He evidently believes that the hereditary tendency to that disease is but a minor factor in its causation, and that this may be overcome by attention to diet, exercise and bathing. The lines, then, that he would suggest should be followed are these :

First, he would have the man *live simply*: Take only sufficient food for the body's needs and no more. Eat fruits and fresh vegetables, spinach, sprouts and greens. Let your meat food be moderate in quantity. Avoid wines and beers.

Then he would insist upon regular physical and mental exercises. Among the former, doubtless walking is one of the best. Fencing, riding, rowing and swimming come next in usefulness. And one must not despise the humble bedroom exerciser, such as Whiteley's or Sandow's, for example. (We find the average American takes kindly and naturally to the "punching bag." We recommend it, in doses of fifteen minutes, for the cares and vexations of this busy world, or even "when the smooth curtain of domestic joy glides less smoothly.")

Lastly, our author thinks it impossible for the goutily disposed patient to do too much bathing. The cool morning tub, or the cool sponge, followed by vigorous rubbing, is an excellent exercise in itself. Vapor baths and Turkish baths are also to be commended.

Dr. Searson is strongly of the opinion that *lycopodium* is a very helpful drug in these cases, and recommends it.—*Journal of the British Homœopathic Society*, April, 1901.

O. S. Haines, M.D.

A FOOD-FOR-THOUGHT CAPSULE.—Dr. Edward R. Snader says: "Ninety-five times out of a hundred, when you have discovered an intercostal neuralgia, you are only upon the threshold of the *real* diagnosis."

O. S. Haines, M.D.

THERAPEUTIC HINTS.—Douglass, of Baltimore, in an interesting potpourri written for the *Hahnemannian Advocate* of February 15th, says among other things:

In vertigo, if the patient is attacked when lying in bed; and if *turning* to either side causes vertigo and a sensation as if the bed were floating, *conium* is the remedy. (Conium repays study in many cases of vertigo.)

Silica.—Vertigo in bed, when turning head to the *left* while lying.

Blinding Headaches.—Chronic headaches are frequently accompanied or

preceded by "blindness," and the following six drugs will most often be indicated.

Kali bich.—Blindness preceding headache, but it disappears as headache grows worse. (*Causticum*, on the other hand, does not diminish.)

Silica.—The dimness of vision or blindness comes on *after* the headache. Gelsemium, iris vers., natrum mur. and psorinum complete this group.

Babies that sleep all day and cry all night are frequently cured by *lycopodium* (this will be good news in many homes).

In prescribing infant foods, it is worth remembering that rice is an astringent and farina a laxative.

Capillary bronchitis very often complicates measles. If you remember that *chelidonium* very often covers these conditions, you will have less trouble in their treatment.

Constipation of baby-food-fed babies.—Alumina is often the remedy.

Harassing titillating cough in children.—Not at all in the daytime, but beginning as soon as their heads touch the pillow *at night*. *Drosera*.

Conium.—The same, but the cough is also very troublesome during daytime.

Chill occurring at 10 A.M., result of hectic fever or phthisis, will yield to *stannum*.

O. S. Haines, M.D.

KALI BICHROMICUM IN KERATITIS.—Dr. Thomas M. Stewart reports a case in *The Journal of Ophthalmology* which illustrates in a striking manner the beneficial effects of *Kali bich.* in certain troublesome eye affections, and which is worthy of notice.

A man, aged twenty-eight, applied for treatment, suffering from phlyctenular keratitis. In spite of approved treatment, the case ran a protracted course. Iritis developed, the superficial phlyctenular keratitis changed to an infiltration of the deeper corneal layers. It looked like a corneal abscess, but it was of the non-suppurative variety of deep corneal infiltration. Under atropin and mercury, the iritic symptoms finally passed away, but still "the patient wished the large white spot cleared away." After failure of various remedies *Kali bichromicum* was prescribed in the 3x.

The indications upon which this remedy was selected were these: "Very little redness or photophobia, no pain or lachrymation, the chronic, indolent form of inflammation." The author concludes that in many of the so-called serofulous cases this remedy is doubtless called for, and the keynote to direct our attention to it is the "chronic indolent" character of the case. In the case above narrated, improvement began with the taking of the *kali bich.*

O. S. Haines, M.D.

SILICEA.—Lawson, of Detroit, has an instructive little *resume* of the therapeutic uses of *silicea* in the March number of *The Medical Counselor*, from which we cull the following:

It is in suppuration that this remedy has shown wonderful power.

Mercury may avert, Hepar promote, but when suppuration is once established, then *Silicea* comes in, and if given in high potency and allowed to act undisturbed, it will produce effects unequalled by any other remedy in use by homœopaths at the present time.

In *simple ulcer*, applied locally and if given in potency, it has but one rival that I am aware of, and that is *Carbo animalis*.

In *abscess*, whether it be pelvic or external, *Silicea* stands chief of remedies. It promotes healthy granulations, prevents undue waste of tissue, and closes the lesion without loss of function.

The author mentions the following clinical picture as indicative of the need of *Silicea*. The picture is a familiar one, although perhaps some would not think of this remedy at once:

"Complete obstruction of the nose—she could hardly talk—found great difficulty in breathing unless she did so through her mouth. Dry and fluent coryza alternately; the coryza lasts interminably for weeks at a time. Fluent coryza following chronic stoppage of the nose. Great chilliness, has to go to bed to get warm."

O. S. Haines, M.D.

TARANTULA CUBENSIS.—This is the dark-brown hairy tarantula found in Cuba, Mexico, and in a few of our southwestern States. Its poison acts directly upon the blood, producing marked symptoms of toxæmia, with quite characteristic local inflammations. The bite becomes quickly surrounded by a dark-red areola some six inches in diameter. The pain is burning and lancinating in character. The area around the bite becomes indurated, becomes gangrenous, and an abscess forms, which may have several openings. Small pimples and pustules appear in parts of the body remote from the wound. In from thirty-six to forty-eight hours chills develop, followed by high fever, headache, delirium, thirst, restlessness and anxiety. The urinary tract is markedly affected, the urine being scanty or suppressed. With this knowledge of some of the more poisonous effects of the bite we are prepared to understand and appreciate the statements of Dr. Mary Elizabeth Hanks, of Chicago, who has quite recently written upon the subject in *The Medical Visitor*. Dr. Hanks claims for the remedy first place in the treatment of serious cases of *furunculosis*, and her experience fully justifies her claim.

One of her cases is so remarkable that we mention in detail its most important clinical features. The patient was a Mrs. X., 66 years of age, who for four consecutive autumns had suffered from *furunculosis*. During the attack which we are considering the furuncles were of the carbuncular type, having several openings, yet did not slough. At one time eight large boils of this sort were present, besides 164 pimples and pustules, mainly upon the upper portion of the left side of her body. Medical attendants of different schools had been employed in vain, heroic doses and the infinitesimals had been employed without effect. Dr. Hanks had taken a few shots at the case herself, but was unsuccessful until she employed *tarantula cubensis*, which quickly assuaged the pains and cured the sad condition "almost magically." The sufferings of this patient must have been extreme, if we may judge from some cases in which but two or three "boils" of this character were present, and we regard these observations as worthy the attention of homœopathic physicians. The Cuban tarantula surely influences these cases more favorably than other remedies, and should not be forgotten. Be sure you get the *tarantula cubensis*, as the Spanish tarantula will not answer. Use the 6x dilution.

O. S. Haines, M.D.

THE TREATMENT OF GALL-STONE CASES.—Dr. Horace Packard, of Boston, in a most interesting series of papers published in *The New England*

Medical Gazette, sums up the Homœopathic Therapeutics of gall-stone disease about as follows :

Calcarea carb. 30x every fifteen minutes to relieve the pain of a gall-stone attack.

Berberis tincture every fifteen minutes, for a similar purpose.

China 6x every eight hours for weeks, to prevent their formation, and, afterwards, at longer intervals still.

Chelidonium tincture expels and prevents formation, has cured numerous cases.

Aconite 3x with hot compresses over seat of pain.

Podophyllin 3x to aid expulsion.

Naturally, he devotes most of his paper to the surgical treatment of the affection, and concludes it with the following significant remarks: "The danger of gall-stone operations is relative. If performed when the general health of the patient is good, and before abscess has formed, there should be no mortality. On the contrary, cases which have become debilitated from recurring gall-stone attacks, when septic absorption has occurred, and the contents of the gall-bladder infect the abdominal wall, a mortality is inevitable." (We general practitioners should take this matter to heart. It is more than probable that any case suffering from recurring attacks of gall-stone colic will some time require surgical interference. It is our plain duty therefore, to seek surgical counsel as early as possible. Nothing will be lost by promptness in such matters, and much may be gained. We feel justified in saying so by the memory of two or three cases of such a nature, in which, we believe, life was sacrificed by useless procrastination.)

O. S. Haines, M.D.

RHUS AROMATICA IN INCONTINENCE OF URINE.—Dr. A. K. Choudhury, in *The American Medical Monthly*, praises the efficacy of this remedy. His method of using it is, however, different, in regard to the dosage, from that in vogue among the physicians who have heretofore written in commendation of its beneficial action in this annoying affection.

Dr. Choudhury administers it in doses of "one globule medicated with the mother tincture." This is a minute quantity of the medicament, compared with the heroic doses of the tincture generally given, yet the results have been quite as satisfactory. The doctor mentions two cases that are striking:

A boy, aged nine years, who had suffered from nocturnal incontinence for a long time. Notwithstanding that he had wet his bed four times each night, he was cured immediately and permanently by the *rhus arom.* after failure of other drugs.

A man, aged 60 years, had suffered from enuresis for one year, subsequent to an attack of intermittent fever. *Symptoms*: Urinates five times during each night and seven times during daytime. Fermented, bad-smelling, diarrhœic stool thrice daily. Burning of palms of hands and soles of feet, and also burning of eyes. Sense of heat upon the vertex. Sleeplessness. Lachrymation. Asthma morning and evening. Enlarged spleen. Infrequent doses of the *rhus arom.* cured him quickly.

We must not overlook the removable *causes* of this affection, many of which are, indeed, mechanical. *Rhus arom.* is one of the remedies that should then be considered, if the disease persists. It is often surprisingly efficacious, and it is strange that it has never been proven.

O. S. Haines, M.D.

THE HAHNEMANNIAN MONTHLY.

JULY, 1901.

THE NON-RHEUMATIC CAUSES OF VALVULAR DISEASE OF THE HEART.

BY J. W. DOWLING, M.D., NEW YORK.

(Read before the American Institute of Homœopathy, Section of Clinical Medicine, June 20, 1901.)

WITH a history of rheumatic fever, the most careless observer thinks at once of the possibility of an endocarditis as a sequel. This, in view of the fact drummed into every medical student that this sequence of events happens in a large proportion of cases. If an endocarditis exists, it is in many, perhaps most, instances, easy to detect that something is wrong with the heart-sounds, hence that the valves are diseased; that the patient is therefore a subject of valvular heart lesion, and the diagnosis is complete. It matters little what the nature of the lesion be, though upon this point rests the entire prognosis, plan of treatment, and expectation of life; the diagnosis "heart disease" covers all, and the sufferer is doomed to carry for the balance of an anxious life the fear of sudden death.

Though sufficiently serious, valvular disease is often so nicely overcome by nature's own resources that even in these rheumatic cases it would be entirely unsuspected but for the association of ideas between rheumatic fever and endocarditis, which prompts the examination resulting in its discovery.

In view of these facts, it may be well to consider, and perhaps endeavor to realize, how often valvular lesions are entirely overlooked, by reason of failure to practice thorough examina-

tion of the heart, when confronted with diseases which have not been so associated in the minds of physicians with this serious sequel. It requires no special skill to detect the mere existence of some cardiac abnormality. A cursory examination reveals something wrong; but even this is, more often than not, omitted, the attention being led astray by symptoms apparently indicating that other organs are diseased. The habit of systematic examination of the heart in every case of serious illness would largely diminish the demand for the services of those who have made special study in this field; and, at the risk of narrowing their field of usefulness, it is the purpose of this brief sketch to emphasize the importance of thorough physical examination, which is sometimes forgotten, too often omitted as consuming too much time, but which is of such vital importance to the welfare of the patient—it might be added to the welfare of the physician also, for nothing so tends to impair confidence as the discovery by an outsider of a heart lesion which the patient rightly believes should at least have been suspected, and for which search should have been made.

To this it might be answered that the field of medicine is too broad for one man to master all the specialties. In this view one may cordially acquiesce; but I believe and maintain that a practical working knowledge of the technique of physical examination of the heart is not a specialty, but an absolute necessity for every man in general practice; nor should it be necessary for him to wait for a history of rheumatic fever before suspecting a valvular lesion.

There are many other causes of this disorder. It might suffice to simply enumerate them, and close with the exhortation to investigate the heart in every disease on the list. It will, perhaps, be of more service to discuss them briefly, with reference to their mode of attack upon the heart, and their significance as to prognosis when cardiac disease results. Furthermore, a knowledge of the various conditions leading to the development of cardiac lesions stimulates the physician to redouble his efforts to ward off this result, and puts in his hands a sword of Damocles to suspend over the head of the patient who is unwilling to submit to the restrictions put upon his habits of life in the treatment of some apparently less important diseases.

The various causes of endocarditis may be roughly grouped, from a clinical standpoint, in two classes. First, those which may be, and with considerable frequency are, followed by this secondary affection; and, second, those in which the heart is sooner or later inevitably attacked—the former to be suspected and watched for a time, until the danger is past, when vigilance may be relaxed; the latter to be kept constantly under observation, that the heart lesion may be detected at its earliest possible moment, and every precaution taken to delay its development and arrest its progress when once begun. The study of this second group opens to the physician a broad field of usefulness, the thorough cultivation of which will result in the prolongation of many lives, and, still more, in extending the period of usefulness and activity of those who, from lack of knowledge, ignorantly pursue habits of life which can end only in speedy breakdown. 'Tis far more profitable to set the danger-signal, and prevent accident, than to busy one's self entirely with repairing damages after the crash has come.

The first of the clinical groups above referred to includes trauma, chorea, and the infectious diseases, embracing, besides, the exanthemata, gonorrhœa, syphilis, and the numerous varieties of pyogenic infection.

Trauma.—In its broadest sense this term should be understood to include not only injury to the valves due to sudden and violent strain, but also the slowly developing results of long-continued over-exertion, even though this be but slightly in excess of the capacity of the heart. The history of sudden damage to the heart is so characteristic that it is not easily overlooked. Usually after some severe effort, as in a tug-of-war contest, or an attempt to catch a train, the patient is seized with breathlessness, palpitation, and perhaps pain in the præcordial region. In such cases one must suspect a rupture of the valve leaflets, usually at the aortic orifice, the site of greatest strain. Auscultation would reveal a double or "see-saw" murmur, heard best at the second intercostal space at the right of the sternum, and transmitted into the carotid artery with its first sound, the second carotid sound being muffled or absent. As a direct result of the sudden embarrassment of the heart the left ventricle dilates, the apex is displaced to the left, and a mitral systolic murmur is often heard, due to the dilata-

tion of the mitral orifice. As absolute rest is the only method of approximately enabling such a heart to recover itself, the importance of detecting this condition is evident. The strain thus thrown upon the mitral valve is sometimes sufficient to set up a true valvulitis, with resulting deformity here. The condition of the heart is then deplorable in the extreme.

While this accident to the valves is not rare, the effect of sudden exertion is more often a simple dilatation, followed by a similar group of symptoms, though the prognosis is much less grave. Mention is made of this condition merely to emphasize the importance of careful diagnosis between it and actual rupture of the valves.

Prolonged and only moderately violent physical exertion, as in athletic training, occupations involving heavy lifting, etc., produces valvulitis in a different way. The continued violent impact of the valve leaflets gradually sets up an inflammatory condition of mild grade, but none the less certain to produce serious results, all the more so as its symptoms do not appear until the heart has begun to give out. Upon the first appearance of dyspnœa or palpitation the heart should be examined, and if there be the slightest suspicion of an altered sound, or if the apex be displaced to the left, the amount of physical labor should be at once cut down.

Chorea.—This disease is included here because it occurs with a certain definite frequency among the antecedents of cases in which no rheumatic history can be determined. It is considered by some authorities as being the cause of the endocarditis, though they fail to give a satisfactory explanation of how this result is obtained; the most plausible theory assuming that the chorea is due to a specific germ, and that this germ, or its poisonous products in the blood, produces an irritation and inflammation of the endocardium. On the other hand, there are excellent grounds for considering chorea as an affection of the motor cortical areas and the basal ganglia of the brain. This leaves blank any connecting link of causal relationship between it and endocarditis. The attempt to supply this link is made by assuming that the pathological changes in the structures of the nervous system depend upon certain abnormalities of nutrition, consequent upon the conditions of the blood itself; that, inasmuch as chorea occurs with great fre-

quency in rheumatic subjects, the blood-changes of rheumatism are its actual cause, and the cases occurring without a history of rheumatism are accounted for by the fact that the manifestations of a rheumatic attack, particularly in the case of infants and children, are often so ill-defined that a diagnosis is almost impossible; hence an attack of chorea without a history of rheumatism practically justifies the assumption of a rheumatic diathesis with obscure symptoms, or none at all. However this question may be eventually determined, it must be borne in mind that chorea is often the only definite point obtainable in the history of endocarditis; that it therefore occupies at least a causal relationship to it, and its occurrence should prompt the physician to examine the heart at regular intervals for at least a year after the final cessation of all nervous symptoms. Not infrequently this length of time must elapse before a mild grade of endocarditis will develop physical signs sufficiently pronounced to be appreciated. The sounds at the mitral valve, *i.e.*, at the apex of the heart, should be the ones most carefully watched, for it is at this orifice that the trouble usually makes its first appearance in cases with a choreic history.

Infectious Diseases.—Among the sequential affections of the zymotic diseases endocarditis is, perhaps, the one least often considered, and for which search is seldom made. Yet it is equally true that, taken as a group, they are second only to rheumatic fever as causal factors, and do eventually produce a large number of cases. An explanation of this fact is comparatively simple. The activity of the various micro-organisms inhabiting the blood itself results in the production of certain poisonous and irritating products. These, of necessity, bathe the sensitive layers of endothelium lining the vessels and covering the valves of the heart. But because of the systemic disturbances existing the heart is beating more violently than normal, and the sensitive surfaces of the valves are brought into rapid and violent contact, resulting first in hyperæmia, as in a simple chafing of the skin, next in swelling, then in exudate in and upon the valves, and finally in cicatricial contraction and a chronic valvulitis, with deformity, develops. The wonder is not that so many but that so few cases result. In all of the zymotic diseases this possible sequence of events should be borne in mind, and its manifestations repeatedly looked for

until sufficient time has elapsed to make it evident that no damage has been done to the heart. How carefully do we watch the urine of a pregnant woman for signs of possible nephritis, yet how seldom does the physician require or take the opportunity to examine the heart a year after his patient has passed through an attack of measles, scarlet fever or diphtheria! And yet these three, of all the infectious diseases, are the ones most commonly followed by an endocarditis, and, in a large majority of cases, of so mild a type that several months must pass before it can be detected. In view of the fact that valvular disease, if detected early, can be so managed as to rob it of most of its serious consequences, while, if undiscovered and neglected, mischief is easily done which is always dangerous, and often fatal, it would seem the duty of the practitioner to make it a routine matter to examine the hearts of all patients who have passed through a zymotic disease at least as late as one year after recovery. This does not imply that, during the course of these ailments, the examination of the heart should be omitted. Even thus early endocarditis will often be detected, and its discovery adds largely to the success of treatment. Failure to detect it until too late, or not at all, accounts for some inexplicably fatal results of apparently curable disease.

In the second group of causes of endocarditis, in which a valvulitis of greater or less degree is an inevitable sequence, we find a great variety of conditions; and, owing to the large number of pathological processes involved, the attention of the physician is more apt to be concentrated upon the primary disease, leading to forgetfulness of the fact that heart lesions are bound to occur, and to failure to discover them until symptoms develop which call loudly for relief, often without avail. Medicines, diet and hygienic measures, admirably adapted for combating the original disorder, frequently become absolutely harmful in their effects upon a crippled heart, and must be replaced by others less inimical to the welfare of the patient. A proper appreciation of this question will necessarily lead to more frequent routine examinations of the heart and to an earlier detection of valvular disease, with corresponding prolongation of the patient's days of usefulness. It may be asserted positively that in time valvular disease invariably cripples the patient, and one of our paramount duties is to discover these

lesions at the earliest possible moment, and endeavor to delay the hour of incapacity for physical exertion.

One might enumerate this second group of causes of valvular disease in the following order, having reference to their relative frequency: Bright's disease, in its broad significance, alcoholism, gout, syphilis and lead-poisoning. Truly a widely diversified list of disease processes. Yet do they all touch at just one point in their pathology; and it is at this particular point that we find they encroach upon the health and well-being of the heart. They one and all, sooner or later, induce valvular lesions, and may thus rightly be grouped into one class. The pathological features, as they affect the heart, are the same in all, varying only in degree and date of appearance. As, in the study of law, certain broad principles cover a multitude of particular cases, so certain uniform pathological processes will be found to explain the manifestations of a great variety of diseases. A study of these processes enables us to anticipate the changes, to delay their development, and to combat their effects.

It is seldom that these diseases produce as a sequel an acute endocarditis, nor do they directly set up a chronic lesion, thus in a measure justifying the popular impression that the heart is practically outside their field of action. Common as it is, this belief is an unfortunate one, for the essential point in all intelligent attempts to combat chronic cardiac disease is its early recognition, and if it be not expected, search for it will not be made, and its development will progress until the point of breakdown.

In whatever manner produced, by whatsoever pathological theory explained, each of these diseases is accompanied by a change in the arterioles and large arteries known as atheroma, arterial sclerosis or arterio-capillary fibrosis. This change consists of a swelling and thickening of the intima or inner coat of the vessels, followed by softening, and later by the development of connective tissue which still later becomes more or less infiltrated with lime salts. Whether primary or secondary, this change in the arterial walls produces very serious results. The elasticity of the vessels being diminished, an added labor is put upon the heart from the fact that it requires much more work to force the blood through tubes with rigid, inelastic

walls, than through the normal vessels, the elasticity of which is an important propelling factor. This extra labor develops additional muscle-fibres in the heart-wall, and there results a slowly increasing ventricular hypertrophy, which is nature's method of overcoming obstacles. If this were the only result it would be of but minor importance. The overgrown heart-muscle, however, requires more nourishment. This it fails to receive because the degenerative process affects all arteries, and by narrowing the calibre and diminishing the elasticity of those supplying the heart, the coronaries, it actually lessens the amount of blood conveyed to the heart-muscle. The inevitable effect is a loss of power and eventual degeneration, its time of appearance depending upon the amount of labor required of the heart and the activity of the exciting cause.

Coincident with the changes in the lining of the arteries, we find the same atheromatous process attacking the endocardium, particularly that part of it covering the valves, because of the greater mechanical irritation to which it is subjected. This inflammatory process inevitably results in changes which interfere with the flow of blood through the orifices of the heart, either because the thickened and more rigid valves do not open freely, producing a stenosis, or because, being contracted and deformed, they do not properly close, permitting a regurgitation. In either case the overworked heart, poorly supplied with nourishment, is still further embarrassed. It fails to respond to calls upon it for its accustomed labor, and very little extra effort will so overtax its powers that its compensatory hypertrophy is converted into dilatation, with a permanent crippling as a result. Much of this damage can be avoided, it can all be postponed, by an early recognition of the developing endocarditis.

Having fully grasped the idea that a valvulitis is likely to occur in these conditions, what are its manifestations, the physical signs by which it may be recognized? Its symptoms are not diagnostic, for in the early stages there may be none; or the symptoms may exist, but depend upon one of several other causes,—for example, a high-grade of anæmia. As the atheromatous process begins in the arteries, it commonly attacks first the aortic valves, by reason of their contiguity. Since this is so, it is the rule to find, first, the signs of aortic disease. I do

not recall an instance of the mitral valve being affected by this process in which the aortic was not also involved, with every probability of its being the primary lesion.

It is a simple matter to detect a well-marked aortic lesion,—the loud whizzing, rasping murmur, being so characteristic. It is more difficult to appreciate in its early stage, and one has often to deduce from other physical signs the inference that the lesion must exist, even though its effect upon the heart-sounds is so slight. These doubtful cases are often cleared up by ordering some sharp exertion for the patient.

The heart muscle, beating too feebly to produce an audible murmur at the site of the deformed valve, will temporarily gather itself together and develop sufficient power to render the murmur plain, at once making the diagnosis clear. The observer should, and, forewarned by his knowledge of what is likely to happen in each of the diseases included in the second group above referred to, will, examine minutely the hearts of all such cases, and will find as early manifestations of aortic disease these physical signs: The apex beat will be somewhat nearer the nipple-line than normal, though still in the fifth intercostal space. The first sound at the apex will be more distinctly valvular, “flapping,” owing to the lessening of the muscular element in its composition, which arises from the lack of nutritive material supplied to the cardiac walls because of the narrowing of the coronary arteries. This lack of muscular quality is the more noticeable because not in accord with the usual “booming” muscular sound of a hypertrophied heart.

At the aortic orifice there will be some modification of the first sound, which will vary from a faint roughening, only perceptible after exertion, to a distinct systolic murmur. This modification will be equally, if not more, marked with the first sound of the carotid artery in the neck, sometimes being easily heard in this location when not perceptible over the heart itself. The second sound at the aortic orifice will be accentuated and of a ringing character, unless the valve has become incompetent, when a diastolic murmur will be heard. Long before the valve has become affected this ringing second heart-sound at the aortic orifice is diagnostic of the rigidity of the arterial walls, which can only come from atheroma, and which is a warning of future developments.

Whatever condition they accompany, this group of physical signs points unmistakably to the existence of a complicating endocarditis essentially chronic in its nature, and with an inevitable tendency to cripple the heart.

The serious consequences of failure to discover this condition when present, and the frequency with which they are overlooked until irreparable damage has been done, must be the excuse for and explanation of this discussion of a topic which may perhaps be considered of minor importance and of too technical a nature. That it is of vital interest and worthy of study I would urge with all possible emphasis.

ARTERIO-SCLEROSIS: ITS ETIOLOGY, CLINICAL RELATIONS, AND TREATMENT.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA, PA.

(An address delivered before the Homœopathic Medical Society of Maryland, May 22, 1901.)

WHEN, several weeks since, your honored President paid me the very high compliment of inviting me to address you this evening, my appreciation led me to reply, without hesitation, "Certainly." But ready replies often lead to leisurely repentance, and so in this instance I had before me a problem not easy of solution, namely, the selection of a subject which would interest the majority of my audience. In other words, the fable of the stork who invited the fox to dinner, and who served the repast in a long-necked flask, was before me as a horrible example. Fortunately, the day specified for the delivery of the address marking an additional milestone in my walk of life offered a suggestion, and the saying "A man is as old as his arteries" forced itself upon me. And so it was that I chose for my subject "Arterio-Sclerosis: Its Etiology, Clinical Relations, and Treatment." The subject, furthermore, appealed to me as practical, because, no matter how specialized a physician's practice may be, whether he be an ophthalmologist, a laryngologist, a gynæcologist, a surgeon, or a so-called humble general practitioner, nevertheless he has an ever-abiding interest in it, if not for the sake of his patients, then for his own

personal welfare. We may all dread reaching the fateful time of life characterized so indefinitely as "past forty," which is subject to a variety of clinical conditions not of common occurrence in youth, and yet it is our earnest desire that we one and all be spared to attain it, and even more are we anxious to fill out the threescore and ten—the days allotted to man. The stability of a building lies in its foundation; the health of the body depends upon the condition of the arteries, and these being diseased, their owner suffers.

The practical side of all medical problems is our ability to prevent, and failing in that, to limit, the ravages of the disease, so that the disabilities and sufferings of our patients shall be reduced to a minimum. Prevention demands a thorough knowledge of the causes productive of the disease in question, and so I first invite your attention to the etiological factors of arterio-sclerosis. Prominent among these is to be placed *heredity*, using this term in its broadest sense to include not only the direct transmission of a tendency to arterial degeneration from parent to offspring, but also the disposition of the members of some families to grow old during the comparatively early years of life. It would really seem as though certain individuals were endowed at birth with but limited vitality. In childhood they are adults in more ways than one, and at the early age of forty-five they are universally recognized as old men. In very many instances we are not obliged to study their habits to determine the origin of their premature senility, for, as family practitioners, we are well aware of the arterial degenerations to which they and their near relatives are victims without exciting causes. In still other instances the tendency to arterio-sclerosis is more limited, and some bad habit or mode of living, or other exciting cause, is necessary for its production; and here, again, certain individuals succumb to external influences much more readily than do others. Many times, as already stated, the arterial degeneration is transmitted by direct heredity; but in others it is through the medium of certain diatheses, prominent among which are gout, rheumatism, syphilis, and the neurotic constitution.

Of the exciting causes, *excessive physical exertion* has been given a very prominent place. The important factors here seem to be improperly conducted exercise or physical labor,

or ordinarily active exercise in persons who have not been properly trained. Investigations show that in properly selected young men an athletic training is beneficial rather than otherwise. It is not so, of course, when attempts are made to accomplish physical tasks beyond the capabilities of the individual. Frequent repetition of such muscular effort has an injurious effect on the heart, and this, in turn, upon the arteries. Numerous examples of this were observed during the cycling furor of a few years ago, at which time many a heart was seriously damaged by century runs or races against time by parties who were not fitted for the tasks. Numerous examples of arterio-sclerosis may also be observed among machinists who have followed a life of great physical exertion. In them the arterial changes are usually secondary to cardiac hypertrophy; sometimes, however, alcohol, improper feeding and syphilis are associated exciting causes. I have seen a number of patients who, in their early days, were hard manual workers, who were ambitious to rise in life, who spared not themselves in their efforts to attain success. By the time middle life was reached their ambitions had been sufficiently gratified, and they were enabled to take things in easier fashion. Following this came a general break-down, characterized by numerous neurotic manifestations, attended by sclerosed arteries. It is usual for the friends of such patients to ascribe the evil results to the comparative idleness attendant upon prosperity. I am inclined to believe, however, that the arterial changes have produced a disinclination for labor, and the prosperity has made it possible for the patient to rest without worrying over the question of support for himself and family.

Neurotic influences are undoubtedly productive of some cases; but here the relation of cause and effect is not always clear. Nervous activity most unquestionably produces increased arterial tension, and this, in turn, arterio-sclerosis. Thus we have an explanation of the early ageing of persons long exposed to worry, anxiety and distress. But, on the other hand, arterio-sclerosis is often manifested symptomatically by nervousness, in which case the latter is an effect, and not the cause. The problem is complicated still further by the influence of nervousness upon an individual's habits, forcing him into restless activity, and sometimes to habitual use of alcohol.

Very important but not sufficiently recognized causes of arterial degeneration are found in certain infectious diseases and toxæmia, notably influenza, typhoid fever, malaria, yellow fever, diphtheria, pneumonia, gout, syphilis, and interstitial nephritis. How commonly do we hear it said of a patient that he has never been well since an attack of one of the above-mentioned acute infectious diseases, and how often does a thorough physical examination discover a dilated heart, thickened arteries, and accentuation of the aortic second sound. It is only too common to find the cardiac condition recognized to the exclusion of the arterial condition. Such patients are prematurely old. Why should they not be? for "A man is as old as his arteries." The most severe cases belonging to this type coming under my observation have been in the victims of the pernicious malarial fevers.

Of the chronic toxæmia, gout is probably the most regularly attended by arterio-sclerosis. Indeed, so strongly do I feel on this point that I would doubt a diagnosis of confirmed gout if the patient exhibited normal arterial walls. The vascular degeneration in these cases is due in the first place to the gouty poison, and in the second to generous feeding and insufficient exercise. Interstitial nephritis is often associated, and this adds to the pathological condition.

Of the ill-effects of syphilis on the arteries I can speak positively. I am all the more anxious to do this because the influence of this poison on the vascular system is not sufficiently recognized, unless it be from a theoretical standpoint. As one's experience increases, he meets with many cases of this disease in which his ordinarily successful remedies fail utterly to bring about good results. Many cerebral disorders in the syphilitic depend primarily upon vascular degeneration. Taking locomotor-ataxia, which disease I believe to be always syphilitic in origin, as another example, I have not within recent years observed a single case in which the radial artery did not exhibit more or less thickening. Unfortunately it is not easy to establish the etiological relation of syphilis to arterio-sclerosis, because very many, if not the majority, of the victims of this constitutional disorder have been exposed to varieties of dissipation, these of themselves being important causes of arterial degeneration.

Habits of eating and drinking are important causes; the former consisting of over-indulgence in food attended by sedentary life, and the latter of habitual use of alcohol. The latter is an especially active etiological factor. Patients may claim that they have never been intoxicated, hence alcohol could not have possibly acted injuriously upon them. But it is not the individual who becomes intoxicated at short intervals that is the victim of arterial changes, for he is destined to succumb to delirium tremens, nephritis, and exposure. With the regular drinker the poison works slowly, and exerts almost its entire effects upon the blood-vessels.

The symptoms exhibited by patients with arterio-sclerosis present the widest possible differences. This is readily appreciated when one recalls the fact that the clinical phenomena must vary according to the particular vessels involved. The diagnosis rests entirely upon the physical examination of the circulatory system, *i.e.*, of the heart and arteries. The radial artery at the wrist is found to present thickened and somewhat rigid walls. In some cases these changes are so far advanced as to give to the palpating finger the sensation of a tendon or quill. The tension of the pulse is increased, *i.e.*, the artery is full between the beats, and considerable pressure is required to obliterate the pulsations. With the sphygmograph the distention of the vessel is shown to be gradual, as evidenced by the sloping upstroke. The summit of the curve is markedly flattened, and the downstroke is characterized by entire absence of the dicrotic wave. Changes may also be found in other arteries, notably in the temporal. This is markedly tortuous, and exhibits the same high tension. The heart is usually found hypertrophied, especially in cases that have continued for any length of time. The first sound of the heart is prolonged and dull, and the second sound over the aortic area is greatly accentuated. In the early stages of arterio-sclerosis, before the vascular changes become perceptible to ordinary examination methods, I think that one is fairly safe in basing a diagnosis upon habitual high tension, as shown by the condition of the radial artery and the auscultation of the heart. Increased vascular tension, when habitual, by distending the arteries leads to compression of the vasa vasorum. The calibre of the latter being thus obliterated, the nutrition of the arterial walls is disturbed and degeneration ensues.

Next we come to study the clinical relations of arterio-sclerosis, and, first, let me present such of its ill-effects as are manifested mechanically. Most prominent among these stands the influence upon the heart. Arterio-sclerosis is attended by increased vascular tension. This throws increased work upon the central organ of the circulation, which necessarily hypertrophies in order to accomplish its added task. For months, it may be for years, this work continues without apparent evidence of a diseased heart. Finally that organ fails in its work, and undergoes dilatation. Then follow relative insufficiency at the mitral orifice, impeded pulmonary circulation, dilatation of the right heart, and finally death.

Another frequent mechanical sequence of arterio-sclerosis is cerebral hæmorrhage. This accident is brought about by the increased vascular pressure and the weakness of the cerebral arteries, especially, however, of the lenticulo-striate artery. It is especially liable to occur during the cold months, when rapid changes of vascular pressure are brought about by sudden variation of temperature, as in going from a superheated, illy-ventilated room into the cold fresh air. This accident is rendered much less frequent than it would otherwise be, because of the usually associated cardiac degeneration.

Aside from the above, there are numerous clinical conditions, presenting the widest possible symptomatic range, due to the nutrition changes arising from arterio-sclerosis. Notable among these, because infrequently recognized, are those relating to the nervous system. One common type is found in nervous hypochondriacal individuals. A description of one case tells us what to expect in nearly all. The patient is usually a man about the age of forty-five or fifty. For years he has worked to his utmost capacity, wearing out brain and body alike. He finally complains of indigestion of the well-known neurotic type, associated with mental depression and possibly constipation. Then his mind dwells on his symptoms. He is forever taking about them. He studies the ailments of his friends, hoping to find some one affected just like he is; but he is never satisfied that any one has had the equal of his sufferings. Finally he has insomnia. He becomes restless in the highest degree, and is a trial to his family and friends. Examination will show thickened arteries, accentuated aortic second sound, diminished

functional activity of the kidneys. I do not wish you to understand that all cases like the one above described originate in arterial changes, for there are some in which the whole trouble is but an aggravation of a pre-existing melancholy temperament, or is brought on by auto-intoxication. So far as I have been able to determine, the class of cases which I have described offers an unfavorable prognosis. Successful treatment is only possible in any case of arterio-sclerosis when the patient gives his entire support to his physician's orders. But these particular patients change medical advisers so frequently that no one is permitted to carry out any systematic course sufficiently long to be effective.

But we are by no means limited to hypochondriasis as a mental concomitant of arterial degeneration. Batty Tuke's investigations of a large series of cases have demonstrated that the vast majority of cases dying insane exhibit more or less advanced changes in the blood-vessels of the brain and its meninges. Clinical experience will bear out this statement, for it is not uncommon, even in very young patients, to find the temporal arteries tortuous and the radial thickened. The urine exhibits the well-known changes of renal inadequacy.

A variety of cerebral symptoms may ensue from anæmia of the brain, such anæmia ensuing upon arterio-sclerosis. Notable among such symptoms may be mentioned simple vertigo, or vertigo in conjunction with more serious phenomena, such as epileptiform seizures. The cerebral anæmia in these cases is due to a variety of factors, as defective arterial elasticity, narrowing of the arterial calibre, and weakened cardiac contractions. Under ordinary circumstances, in the initial stages of the disease, the conditions are such that no symptoms obtain as long as the patient is quiet or makes but moderate mental or physical effort. Let him subject his brain or body to unusual strain, and symptoms appear.

Cases manifesting epileptiform convulsions are rare. When they do occur, they present important distinctions from idiopathic epilepsy, in that they are early associated with marked psychical disturbance, including general apathy, dulness of comprehension, feebleness of intellect, irritability of temper, speech disturbances, tremor, paralyses, and even delusions. All of these various phenomena may and do occur without the association of convulsions.

Aside from the mechanical effects on the heart, as already cited, the nutrition of that organ suffers so regularly in arterio-sclerosis that we may with good reason speak of it as cardiovascular disease. This department of the subject was first studied by Gull and Sutton, and in more recent years by Huchard. They found the minute arteries of the walls of the heart much thickened by the formation of hyaline-fibroid substance. The muscular fibres supplied by the affected arterioles undergo degeneration, and are replaced by a fibrous structure. Necessarily, then, the heart becomes incompetent. This will be evident clinically by dyspnœa or slight breathlessness, especially on exertion, and by the intercurrent of syncopal attacks. The coronary arteries themselves may be atheromatous, and this condition, in conjunction with the heightened vascular tension, leads to paroxysms of angina pectoris. In all of these cases physical examination of the heart will discover a decided weakening or muffling of the muscular element of the first sound at the apex, a point to which altogether too few physicians pay attention. The absence of cardiac murmurs is not a good criterion of the soundness of the heart.

The most commonly observed pathological association of arterio-sclerosis is the contracted kidney. In fact, I would say that arterio-sclerosis without some degree of renal degeneration cannot exist. In making this statement I know I am treading upon debatable ground, for many physicians will assert that they have made observations demonstrating the inaccuracy of this statement. They declare that they have seen cases in which the urinary examinations, repeatedly made, failed to discover any evidence of renal disease. No doubt this is true of urinary examinations as ordinarily conducted. The error arises from assuming that a normal urinary specific gravity and the absence of albuminuria betoken sound kidneys. If the clinician will but regard the kidneys as organs of excretion capable of eliminating a definite quantity of urine of standard composition under standard conditions in a given time, say twenty-four hours, he will find that few kidneys are sound when their owner exhibits arterio-sclerosis. Only a few nights since, I was summoned in consultation by a medical friend to see a patient who had suddenly become hemiplegic. Arterio-sclerosis was present, and I stated my belief that renal disease existed.

He declared that this could not be, because the urine contained no albumin, and was always of normal specific gravity, and it contained a normal percentage of urea. The patient died within a few minutes of my arrival. An autopsy discovered kidneys so markedly contracted that it was a wonder they were able to secrete any urine whatever.

Cases of this obscure character are the exception. Nearly always we find a history of polyuria, especially at night, the urine being pale in color, and of low specific gravity. Albumin is found in small quantities in about half the cases as a regular thing, and if repeated examinations are made, few cases will exist without this symptom. Nevertheless, I would caution my hearers not to depend upon it for diagnostic purposes; much better, indeed, to rely upon the microscope, and upon the chemical examination of the urine as a whole.

A more rarely observed association of arterio-sclerosis is asthma. I say rare, because I have never observed a case of the latter disease in which the arterial degeneration was especially marked. Nevertheless, even in the young, the arteries in patients with spasmodic asthma do exhibit some degree of thickening, and the sphygmogram shows the rounded summit and the absence of the dicrotic wave so suggestive of arterial changes. Localized chronic pneumonia and vesicular emphysema are also commonly associated with arterio-sclerosis.

Finally, permit me to devote a few words as to syphilis and arterio-sclerosis. I am fully aware that some of my friends think that I exaggerate the importance of this disease as a destroyer of health. Accepting their criticisms, I am willing to wait for the future to decide as to the correctness of my views. Twenty years ago nervous syphilis was a mere clinical curiosity, not because it did not exist, but because it failed of recognition. Now it is well known that it ranks among the most common of the late manifestations of syphilis. I might say that at the present time syphilis of the heart and lungs, though an admitted pathological possibility, may be of more common occurrence than we are willing to admit. It is very easy to make mistakes. It is not safe to assume that because a man is at present of highly moral character, therefore he has always been so. The dignity of middle life is no guarantee that the follies of youth were never committed. The assumption of some syphilo-

graphers is that syphilis among the upper classes is a mild disorder, made so by the treatment they receive from their physicians, and their attention to hygienic details. This again I deny, and from repeated personal observation. Returning to the clinical aspects of my subject, I would say that there is a very large class of diseases not ordinarily classed as syphilitic, and yet dependent upon syphilis. The vascular system plays an important part in their production. Although the nervous system is the portion of the body most liable to suffer, many organs may be involved. The lesions are of a degenerative character, and result from lowered nutrition by reason of the diseased blood-vessels. They are not amenable to anti-syphilitic measures, because they are in no sense syphilitic lesions.

The future of patients with arterio-sclerosis depends in great measure upon the care which they take of themselves. They may, for prognostic purposes, be regarded as prematurely old. When ill with some acute disorder, the outlook is rendered more or less unfavorable by reason of the vascular degeneration; and if they are obliged to undergo a surgical operation, they react but slowly. Nevertheless, careful management will do much in the way of saving life during acute illness, and retarding the advance of the arterial changes.

Among the hygienic measures, diet and exercise occupy the first place. Alcoholic beverages of all kinds should be absolutely prohibited. The diet must be sufficiently generous to give strength to the patient, and yet it must not tax the organs of excretion. Bearing in mind the relationship between arterio-sclerosis and gout, and the effect of highly nitrogenous food upon vascular tension, the patient should exercise due care as to the quantity of red-meats consumed. I do not favor the absolute prohibition of such articles, because in this way patients are rendered anæmic, and general nutrition suffers. No absolute rule governing all cases can be formulated. It is merely sufficient to bear in mind that nitrogenous food should be used with care; with how much care will be determined by experience with individual patients. To force patients to any hard and fast dietetic rules is bad practice. The use of special preparations, as meat extracts, soups, etc., is hardly to be recommended for the purpose of giving strength. It is better by far to give something having a definite and known food value.

The ability of the patient to take nitrogenous food with advantage will depend in great measure upon the associated treatment. If the patient can be induced to take large quantities of water daily, much will be accomplished, as free water-drinking is the best possible means of eliminating the effete materials originating in imperfect oxygenation of nitrogenous waste. In practice it is astonishing to note how small is the quantity of water which some persons consume, oftentimes but six to twelve ounces in the twenty-four hours. It must be insisted that the patient drink two quarts in that period of time. He may declare that he cannot do so, but a little effort and some experience will teach him better. Possibly if he is directed to take Buffalo lithia, Carlsbad, or some other equally well-known water, he will have no trouble in following directions.

And next comes the question of exercise. When giving advice concerning this treatment, the greatest discretion must be used. The vast majority of patients with arterio-sclerosis have weak hearts. To order such to be at all active is apt to do harm. Whatever active exercise ordered should be carefully graded, and the effect on the heart studied before anything more severe is permitted. Any movements which produce breathlessness, even in a slight degree, must be prohibited. Moreover, the effect of the exercise on the pulse should be studied. If the pulse maintains an unusual speed for more than a few minutes after the patient has begun to rest, then we know that the task was too severe for the heart. Some patients are best treated, for a time at least, by absolute rest, the beneficial effects of exercise being secured by skilfully applied massage.

It is not always an easy matter to get patients to attend to the above directions; they have not the time, or they lack the force of will to inconvenience themselves to the extent necessary. Then, if their physical condition will permit, they may be directed to go to Carlsbad or some similar place. In a health resort all persons conform to the standard set for them; for example, rising at 6 A.M., walking a few hundred yards or more, and drinking of the waters from the springs,—listening, the while, to the music. Later, they are bathed and rubbed; they partake of frugal meals set before them, and they murmur not. It is part of the cure. The only advantage

to be obtained at such a place is that the patient is far from home, and business cares are left behind. This latter is a very important item in the treatment, for emotional excitement does increase vascular pressure, and this of itself, with the disturbed action of the heart, will in time induce arterio-sclerosis.

No empirical medicinal measures can be recommended in the treatment of patients with arterio-sclerosis. Inasmuch as the range of conditions and symptoms which may arise from this pathological condition is an extended one, the possible therapeutic suggestions are many,—too many, indeed, to even mention in this connection. It will be my purpose, therefore, to name but a few drugs having a definite relation to the condition under review, and to refer to certain common fallacies in vascular therapeutics. I believe that there are no drugs more efficient in the treatment of arterio-sclerosis, when the symptoms fail to indicate any one special remedy, than the iodides. In cardio-vascular degenerations, however, the preference should be given to the iodide of strontium or the iodide of sodium. I have used them with about equal frequency, but cannot say that one should be preferred more than the other in special cases. The doses employed should be small, *i.e.*, about five or ten grains, well diluted, after meals. The use of the drug must be maintained with regularity for a period of many months. And it is in this respect that the general practitioner accustomed to the management of acute cases makes his mistakes. He expects results too soon. He has not the patience to enforce one particular line of treatment for a prolonged period. In the disease in question the results are to be obtained only after a long time. A very good illustration of the lesson I am endeavoring to teach is found in a case of mania which I was requested to see in consultation. The treatment inaugurated by my colleague was one which met with my hearty approval, but inasmuch as no result had been shown in three days, he was inclined to discard it. He was surprised when I told him that I would be highly pleased to see marked improvement in three months, and would rest satisfied if the patient was cured in six months.

Another drug of which I am fond is the chloride of gold and sodium. I give this in the second decimal dilution, in doses of five drops, three or four times daily. It is especially appli-

cable to cases in which the renal element is prominent. One may use also the plain aurum mur. 2x, but I would suggest that the dilutions be made in water to avoid the staining effect observed with the alcoholic dilutions.

Attention to the stomach is always an important item in the treatment; indeed, I might say that if I were forced to rely upon any one special line of treatment, it is this which would not be neglected. Ordinarily, we find that *nux vomica*, *bryonia* and *lycopodium* answer every purpose, as the gastric symptoms present usually indicate one of these polychrests. But there are cases in which the flatulence is very distressing, and, indeed, interferes sadly with cardiac action. Under such circumstances, I not infrequently prescribe subgallate of bismuth or betanaphthol-bismuth, usually in doses of ten grains, before meals. As to the former, when cardiac action and the general strength are below par, it is a wise plan to prescribe it in combination with strychnia sulphate, one-thirtieth of a grain at a dose. As to the latter, care should be observed that a good preparation is prescribed, avoiding the mixture ordinarily sold under that name. Hence it is wise to specify the chemically pure, known in the trade as orphol. The well-known combination-tablet, consisting of nux, carbo veg. and pepsin, each in the first decimal trituration, is sometimes very efficient. But these medicines may be distressingly inefficient, and require the assistance of abdominal massage. If a skillful masseur is not available, a fair substitute will be found in the so-called cannon-ball massage, a five-pound shot, covered with chamois skin, being rolled over the abdomen for a period of five or ten minutes night and morning. This mechanical measure is, furthermore, useful in promoting intestinal peristalsis. While the local condition of the stomach is such as to be benefited by lavage, I would caution my hearers against employing it. The introduction of the stomach-tube is contra-indicated in all cases characterized by weak heart. Many cases of the character under review are positively injured thereby, as evidenced by increased breathlessness and weakening of the left ventricle, notwithstanding the amelioration of the gastric symptoms. Even in cases in which the tube does not produce these dire results, its use is of questionable propriety, because it throws increased burden on an already weakened heart acting under unfavorable conditions.

Attention to the bowels is also important. Ordinarily, regular action may be secured by massage, enemata, and our usual remedies. When these fail, one may have recourse to Hunyadi or Apenta water, taken before breakfast. The suitable dose must be decided by one's experience in individual cases. Not infrequently, after securing a regular habit for a week or ten days, the patient is enabled to have a daily stool without the assistance of medicinal measures. It may be that the constipation is an important item in the production of the flatulence in these cases. Under such circumstances, ten grains of bismuth subgallate, with two grains of dry extract of cascara, taken three times daily before meals, will help.

There is altogether too common a tendency to the injudicious use of heart tonics in cardio-vascular disease. And the number of ways in which these drugs may be used injudiciously is astonishing. The proper drug may be administered in either exorbitant or inefficient doses, or one drug may be prescribed when another is indicated. The greatest care should be exercised that the vascular tension is not influenced unfavorably by their administration, or that an already lagging heart is not irretrievably ruined by the over-stimulation. If in doubt, give no cardiac tonic. Digitalis, notwithstanding its high reputation, is by no means the first to think of. Personally, the sulphate of sparteine, in doses of one-twentieth of a grain every four hours, has given the most satisfactory results without exerting the slightest injurious effect. If the cardiac action is irregular, digitalis may be thought of. Here I use a good fluid extract in doses of one or two drops three times daily, or the infusion made from the English leaves. If there is no urgent indication for cardiac stimulation, then the nutrition of the heart may best be maintained by iodide of arsenic, the second decimal trituration, one tablet four or five times daily.

The vaso-dilators, of which glonoin is the most frequently prescribed, should likewise be used with the greatest care. I doubt very much if their continuous exhibition is ever advisable. They should be advised only when the heart is acting feebly under high peripheral resistance. Time after time have I seen glonoin prescribed in disturbed heart action when the pulse tension was below normal—certainly a most ridiculous course; one, too, that may well prove to be disastrous. In an

ginal attacks a more rapidly-acting drug than glonoin is required; then we may resort to nitrite of amyl by inhalation. In some few cases I have used erythrol tetranitrate in the half-grain tablets with most excellent effect. This is a good drug to be continued over several days, when vascular tension continues high. A most important cardiac stimulant is the recently introduced suprarenal extract. It is to be used only in cases of failing heart with low arterial tension. Its use will appeal especially to the surgeons who, after abdominal and other major operations, find the heart going to pieces, the arteries being thickened and insufficiently filled. I say its use will appeal to the surgeon, and I have already said that patients with arterio-sclerosis bear surgical operations badly. Quite recently this drug was put to a severe test in a patient upon whom Dr. Van Lennep had done a cholecystotomy. Apparently dying in the evening, after five grains of the dried extract he made a prompt rally, which proceeded uninterruptedly, although the drug was repeated three times daily for forty-eight hours longer.

When dropsical conditions supervene a diuretic drug is necessary. Here *apocynum* or *digitalis* may be all that will be required. These failing, we may resort to *calomel*. The diuretic action of this drug is not sufficiently appreciated, and, moreover, it is, as a rule, given very inefficiently. Two grains should be administered three times daily. The dose may be surprisingly large to you, as it was to me. In but few cases does it produce an undesirable degree of purging. It may even happen that the bowels are scarcely affected. Still, excessive action in this direction would not deter me from using it. As a rule, the diuretic action is not obtained until the fifth or sixth day, when it appears suddenly. Care must be exercised in the use of calomel lest the patient be mercurialized. The drug should be stopped on the appearance of the slightest tenderness of the gums.

In January of this year Abrams published a note concerning the cardiac reflex. He demonstrated that, following stimulation of the skin in the præcordial region, there ensued a diminution in size of the heart. He suggested that this be utilized as a therapeutic measure. His suggestion impressed me favorably, and I would advise the use of the faradic brush for exciting such stimulation.

But with all the therapeutic measures we may devise, the cardio-vascular patient, even in the midst of improvement, is an uncertain quantity. After we have gotten him about and possibly attending to business, he is, nevertheless, a broken reed. He cannot depend upon his health in the midst of competition in the business world; hence, if possible, he should be forced to lead a life of comparative rest.

The consideration of the treatment of cardio-vascular disease in its entirety is a very big subject; it really embraces all things pertaining to the management of all patients at or beyond middle life. I have endeavored to present to you such points only as appeal to me as of the most importance.

My remarks have been prolonged far beyond the limits I originally intended. My apology rests upon the never-ending phases of arterio-sclerosis, a complete description of which would be like the brook, and "go on forever."

SUGGESTIONS OF THE PRESENCE OF NERVOUS AFFECTIONS TO THE GENERAL PRACTITIONER.

BY JOHN J. TULLER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

IN the diagnosis of disease, one of the most important requisites of a diagnostician is his ability to observe and recognize what one might call the *leads* of a patient; in other words, the condition and symptoms that point to or suggest the origin and location of his disease. It is strange how soon one can become an adept at a quick diagnosis, really at sight, by a little careful study of this subject, with subsequent complete examination for confirmation.

What physician, upon seeing a patient present himself with jaundiced skin and conjunctivæ, would not have suggested immediately to his mind the possibility of disturbance of the liver or gall-bladder? A patient complaining of pain and tenderness in the right lower abdomen immediately suggests appendicitis. The gradual wasting of the body-weight and strength, with the pallor and peculiar make-up of the patient,

would suggest pulmonary tuberculosis. And so it is in nervous diseases. To give a detailed review of these suggestive conditions and symptoms would require too much time for a paper to be read before a society; but I want to bring out a few of these symptoms, as it may lead you to observe these points in the patients that come before you for examination. As you open the door of your reception-room, a patient, coming to you for the first time, rises slowly from his chair, fixes himself in a standing position for a moment, the head and shoulders bent forward, the face bearing a vacant expression, the eyes staring straight ahead; he starts to walk with a short, half-trotting gait, almost upon his toes; you recognize immediately and almost surely a paralysis agitans. He rises with a good deal of muscular force, putting on his best appearance; he raises the foot high, stiffens his leg out as he thrusts it forward, the foot wavers in uncertainty a moment, then strikes the floor heavily, with the greatest force upon the heel, and you have a strong suggestion of locomotor ataxia. Another gait that can easily be confounded with this is that of multiple neuritis. The patient lifts the foot high, throws his leg forward in such a way as to make the force of the movement extend to the foot, taking the place of the paralyzed extensor muscles, and the foot comes down rather heavily upon its ball. The patient rises with some difficulty, and as he assumes an upright position we find that one arm drops, partially flexed, to the side, he starts to walk, and the leg on the same side drags stiffly with some degree of spasticity, describing, as it moves forward, a half-circle, and we recognize a hemiplegia, almost certainly of intracapsular origin. True hemiplegias always wear away the inner surface of the toe of the shoe on the paralyzed side. If we add to this an irregular twisting movement of the paralyzed part, always involuntary, of course, aggravated upon voluntary movement, the condition is one of athetosis and shows irritation of the cortical surface of the brain, or sclerotic changes in the motor tracts of the medulla. If the patient presents an atypical hemiplegic gait, but, instead of dragging the foot in a half-circle, drags it in a straight line, it is suggestive of hysteria. Hysterical hemiplegias wear the sole of the shoe away directly across the face of the toe. If he rises with some difficulty, and, as he starts to move forward, we find that it is with the greatest exertion

that he forces his limbs forward, on account of a peculiar spasmodic condition of the muscles when brought into action, we have suggested amyotrophic lateral sclerosis and spastic paraplegia. Add to this the peculiar history of the development and the short, club-like foot, with an abnormally high instep, and the condition is one known as Friedreich's disease. Sometimes this peculiar spastic gait will be found in disseminated sclerosis, but the patient presents, associated with it, the marked intention tremor of the head and upper extremities. It will again suggest hysterical spastic paraplegia; but the history of the case and the well-fixed hysterical symptoms will clear the case up. We find a man rather advanced in years approaching slowly, carefully picking his way, raising perhaps one foot high from the ground and with the next step scraping the ground, with twisting, almost writhing, movements of the shoulders, head and arms, with the face constantly in grimaces, and we can almost positively diagnose Huntingdon's chorea. A child approaches with jerking and irregular twisting movements of one or more limbs, perhaps involving the face and head with the same movements, and we have the chorea of childhood suggested. Again, we find a child pursing up its lips or screwing up its nose, or drawing down its eyebrows, screwing up its nose and blowing its breath at the same time, and we confirm, on examination, a habit-chorea which is purely voluntary. It must be remembered, however, that these grimaces either follow each other in very rapid succession, or the special facial contortion will be persisted in for a half to one minute. A sharp, explosive, spasmodic jerking of the arms, the head, every muscle of the face, and often involving the trunk, is indicative of a convulsive tic. A further disordered gait is produced by vertigo. Aside from the fact that vertigo is associated with acute and chronic conditions of the brain, and from the involvement of many of the organs of the body, it suggests especially diseases of the facial ganglia, more particularly if it is persistent. Special forms of vertigo, like rotary movements to the right or left, will suggest diseases of the labyrinth, or of one or the other lobes of the cerebellum, according to the direction in which the patient rotates, and abscess of the cerebellum. A patient comes complaining that he finds it difficult to walk in the dark, or, on bending over to wash his face in the morning,

he is compelled to grasp something to keep from falling, suggestive immediately of the static ataxia associated with tabes. So much for the gait.

Of the tremors, we find fine and coarse tremors, intention and non-intention tremors, etc. A patient presenting a fine tremor, which she says fills every muscle of her body, suggests goitre. A fine tremor, again, suggests exhaustion, toxic neurosis like alcoholism, tobacco, mercury, lead, and carbon disulphide poisoning. A coarse tremor of wide amplitude, aggravated by voluntary motion, is suggestive of disseminated sclerosis, as is also a rhythmical move of the head. The tremor of paralysis agitans is a peculiar rhythmical pill-rolling motion of the hands, increased when at rest. Tremor of the tongue suggests exhaustion, toxic neurosis, such as alcoholism, tobacco, and mercury poisoning, as well as paresis.

Twitching of the eyelids suggests exhaustion, alcoholic and tobacco neurosis, and eye-strain. General semi-convulsive twitchings of the face indicate alcohol, tobacco, and mercury poisoning. As you strip off the baby you notice a fine fibrillary twitching of the skin. The suggestion is disease of the multipolar cells of the anterior horns of the spinal cord. This may occur in disease of the anterior horns themselves or involvement by extension from a syringomyelia.

Again, we observe bone degenerations. A patient presents himself with material increase in bone structure over the body, particularly the face, hands, and feet. This increase following more or less the regular outline of the normal bone structure, we have the suggestion of acromegaly. In this disease the face becomes enormously enlarged; the fingers and toes markedly broadened and generally thickened, until the hand resembles a spade in form and shape. Enlargement of the ends of long bones with signs of degenerative changes in the bone structures, and frequently associated with marked deformity, which is so often taken for arthritis deformans, may prove to be a tabetic arthropathy, or the structural bone-changes appearing in syringomyelia. We should be suspicious of corns and callouses. Not infrequently do we raise the outer scale of a corn and find a small, deep, circular hole into which we can pass a probe, and which may prove to be the round, perforating ulcer of locomotor ataxia or syringomyelia. It is not uncom-

mon to find these perforating ulcers in syphilis, but the active stage of the disease will differentiate it. We find, too, occasionally, a peculiar dry-rot of the extremities, not unlike leprosy, but more rapid in its course, and subject to periods of acute gangrenous inflammation, which should suggest syringomyelia. A patient comes to you and lays his hands on your desk, complaining that they are cold and numb. On examination you find them cold to touch, almost death-like, dark, purplish-red, with whitened tips of fingers, and you recognize Reynaud's disease or local asphyxia; a vasomotor change.

Of the atrophies, we find them local and general, of central and peripheral origin. Atrophy of one side of the tongue, with disturbance of sensation on same side of face and progressive facial paralysis, would suggest degeneration of the medulla, gummatous, tuberculous, sclerotic, etc. Atrophy of the lips and tongue muscles, generally of the lower face, suggest an oncoming bulbar paralysis. Localized atrophy in one arm, with paralysis, would suggest a compression paralysis, such as is found in habitual drinkers who sleep with their arms under their heads, as well as a localized neuritis, or perhaps a circumscribed change in the anterior spinal gray matter. Paralysis and atrophy of the extensor muscles of the hands would indicate lead-poisoning. Atrophy of the extensor muscles of the feet would indicate alcoholic neuritis. General and progressive atrophy would suggest disease of the anterior horns of the spinal cord. General atrophy with pain over course of nerve-trunks, associated with marked tenderness, is invariably multiple neuritis. Atrophy general over the body, without nerve-pain or signs of spinal-cord degeneration, is strongly suggestive of myopathy or disease of the muscles themselves. We find occasionally a patient with gradually increasing muscle volume and hardness, and equally progressing muscle weakness. This is strongly suggestive of pseudo-hypertrophic paralysis.

Of deformities of the spine, scoliosis or abnormal curvature of the spine is the most common. A certain amount of spinal curvature is normal from the heavier muscle development on one or the other side of the body. Excessive spinal curvature suggests immediately stripping the body clean and examining the spine. Not long ago I stripped for examination a child of twelve years, who had been before some of our most brilliant

neurologists, but this precaution had been neglected. I found that the abnormal curvature was corrected the moment I placed the thickness of three medical journals under her left foot. It suggested a short leg, Pott's disease, and syringomyelia.

In regard to pains, I wish to divide them, when occurring in the body, into three classes—the burning pain of peripheral nerve-irritation, the lancinating pain of spinal origin, and the boring, aching pain of rheumatism. Thus we find the sharp lancinating pain suggests locomotor ataxia, and frequently syringomyelia, when the posterior columns of the cord are attacked. Sharp burning pains down the posterior aspect of the thigh suggests sciatica, as does this same pain down the anterior aspect of the thigh suggest inflammation of the anterior crural. Pains spreading from the spine in both directions around the body, sharp cutting in character, associated with more or less tenderness, suggest locomotor ataxia. The so-called *girdle-pain*. If associated with an eruption: herpes zoster. The sharp burning pain coming around from the back over the abdomen is suggestive of lumbo-abdominal neuritis. Pain and exquisite tenderness on light pressure in circumscribed spots over the chest suggests intercostal neuralgia (so-called). Sharp lancinating pains in the abdomen, without gastro-intestinal involvement, indicate the abdominal pains of tabes. Tenderness over the spine on pressure indicates disease of the bony column or its membranes, and frequently hysteria, from their constant suggestion that the spine is affected. True disease of the spinal cord never displays pain on pressure over the vertebral column. Pain in the occiput, associated with pressure and aggravated by exertion, indicates neurasthenia; aggravated by using the eyes suggests eye strain. This pain, with pressure on the vertex, is a very common symptom of hysteria. Another very suggestive pain of neurasthenia is the so-called “lead cap,” a sensation as if the head were enveloped in a lead cap or form. Intense occipital pain, associated with vomiting and rotary vertigo, suggests cerebellar tumor or abscess. That constant dull aching pain in the head, growing intense at night, is one of the true symptoms of syphilis. Periodical frontal pains, coming on at the same hour every day or every other day, are indicative of malarial toxæmia. The loss of the ability to differentiate between pain, heat, cold and touch, the so-called disas-

sociation of sensibility, would suggest syringomyelia, hydro-myelia, specific spinal meningitis, and hysteria.

The alterations in sensation become remarkably characteristic, sometimes. It must be remembered that alteration in sensations arising from diseases of nerves follows the course of the distribution of those nerves. These changes, due to degeneration of the sensory segments of the cord, occur in the portion of the body supplied by the sensory nerves, and this disturbed sensation follows the course of the nerve over its entire distribution; therefore, when we find an area of anæsthesia encircling the limb—for instance, at the ankle, like a shoe; or at the knee, and affecting everything below, like a stocking; or about the hand, like a glove,—it is not only suggestive but proof positive of hysteria.

While you are studying the heart, remember that palpitation is a very frequent symptom of the functional neuroses, such as hysteria, neurasthenia, and the climacteric period. Patients who come complaining of indigestion, or severe attacks of pain in the stomach associated with indigestion, are not all affected by diseases of the stomach. This symptom is a very frequent one in tabes, as is the sudden attack of profuse diarrhœa without apparent cause—the gastro-enteric crises of tabes. Intense itching of the sulcus ani close to the anal ring is sometimes a very early and a very suggestive symptom of tabes. Too much stress cannot be laid on suggestions of incontinence of urine and other signs of bladder-weakness as early symptoms of tabes—the bladder crises of tabes.

DROPSY—(A FRAGMENT).

BY WESTON D. BAYLEY, M.D., PHILADELPHIA.

(Read before the A. R. Thomas Club.)

THE paradox of fluid successfully held under pressure in a container made of porous meshwork is one of the common miracles of Nature manifested in organic structures. The container, however, is thoroughly and continuously wetted by its liquid contents, for indeed its integrity and vitality is depend-

ent upon the materials carried to it by the fluid within. These lymph spaces thus moistened have been aptly compared by Lauder Brunton to cisterns, "each of which is provided with supply pipes, the arteries and capillaries, while there are two exit pipes, the veins and lymphatics."* In health, the balance between the inflow and the outflow is such that the spaces are merely moistened with fluid. Let there be certain disturbance of this balance, and the normal moisture becomes the abnormal œdema or dropsy.

I say certain disturbance, for we are not sure that the merely mechanical changes resulting from venous pressure are the real cause. Ranvier's experiments rather showed that mere ligation of a venous trunk was not sufficient to cause œdema; nor did œdema result when, in addition to this, he cut the motor root of the nerve supplying the limb experimented upon; but when he divided the vasomotors of the part, the limb rapidly became œdematous.

It is likely, therefore, that there are a number of factors at work in this overflow into the lymph spaces of the body—the chief one being a disturbed integrity of the vasomotor nerves (vasomotor paresis). Beyond this is an aqueous condition of the blood, disturbance of blood pressure, the nutritive state of the capillaries, upon which depends some unknown but specific action of the endothelium, which ultimately regulates the quantity and character of the nutritive secretion to the tissues.

Illustrating these factors, we find a pure vasomotor œdema in the paralyzed limbs of the hemiplegic; a pure obstructive œdema from the obliteration of a vein by pressure of a growth; a pure aqueous œdema in the puffiness of anæmic states; and a specific œdema due to the action of certain drugs.

Whatever may be the real mechanico-dynamics of dropsical effusions, we clinically know of fluid, varying somewhat in its chemical constituency, collecting in abnormal quantities in the tissue meshes and serous cavities of the body; such collections being merely symptomatic of some existing disorder, but in their turn producing secondary symptoms by mechanical interference.

The local dropsies caused by venous thrombosis, growths,

* Landois and Stirling.

liver hypoplasms, and that due to obstructive diseases of the lungs, will not be discussed in this paper, but will probably be given consideration by some of the gentlemen who open the discussion. In this essay our attention will be limited to the serous effusions and the œdemas of cardiac and renal origin.

Valvular diseases of the heart, of whatever character, have the general tendency to obstruction of the venous return; there is a transference of the blood-pressure from the arteries to the veins; and, since the thoracic duct enters into the large veins, the flow in the lymph-channels must be also included in the stasis which results. This mechanical view of venous obstruction from heart-lesions, causing dropsy, has, however, been deemed inadequate by some observers. While not denying the frequent association of heart disease and fluid accumulation, these writers point to the quite numerous instances of very serious and theoretically suitable cardiac disorders without the least sign of œdema.

Walshe, after citing a number of these instances, says: "I cannot, then, see how the conclusion is to be avoided that something beyond, and in addition to any one or any group of the cardiac conditions referred to, is required in order, as a matter of necessity, to entail the occurrence of dropsy. . . . And, again, the existence of some active cause beyond and independent of the heart is further shown by the facts that there is no direct relationship between the amount of heart disease and of dropsy; that dropsy comes on suddenly sometimes from extraneous causes, the state of the heart remaining, as far as ascertainable, in precisely its previous condition; and that dropsy diminishes and increases, comes and goes, either spontaneously or through the influence of treatment, while the organic changes in the heart remain permanent and unmodified."

The essayist does not feel competent to take sides in this dispute as to the adequacy of venous obstruction in accounting for cardiac dropsy, but the inference is that we are still in considerable ignorance about some apparent pathological activities, and that we are particularly so in reference to the possible specific functioning of certain ultimate cells.

The mechanism of renal dropsy, too, is not as easy as it looks at first blush. The idea that it was the deficient elimination of fluid was so obviously negated by many cases, that

Conheim was led to surmise an abnormal perviousness of the vascular walls. This has not been demonstrated, and, indeed, is not largely believed. Here again is a question which in our present pathology is unsolved.

In acute nephritis dropsy may or may not be present. Heaven save us from the doctor who relies upon its absence to negative a diagnosis of acute renal disease!

With a large white kidney the presence of œdema and serous collections is more uniform. In the interstitial form it is usually absent until late, or else manifests as a slight infraorbital œdema or mere puffiness over the ankles. The cases which late in the disease are associated with dilated heart often have fluid wherever fluid can collect, and then are positively deformed with dropsy.

The author need not call your attention to the fact that this is not a monograph on dropsy, but merely a skeleton framework which he hopes will be covered in your discussion of it by the living flesh.

Reference to mechanical, adjuvant, dietetic and hygienic treatment is here omitted. I have just a few hints about treatment; of course these can only be general. The peculiarities of the individual case must be our ultimate guide to treatment. Removable causes must be removed. If heart-lesions are present, their exact character must be ascertained. This applies not only to valvular states, but to mural and pericardial conditions as well. If the kidneys are damaged, we must determine, if possible, the particular form and extent of the lesion, and the amount of kidney competency existing without therapeutic assistance.

Theobromine (Merck's) has been, in my own experience, one of the most satisfactory remedies. The plain substance has served better than any of the combinations of theobromine with other drugs. It is best used in from two- to eight-grain powders or capsules. Frequently I have made twelve two-grain powders, directing that the first four should be given every two hours, the second four every three hours, the third four every four hours. Some cases have been so susceptible that gr. ss. would increase the urine from twelve to sixty ounces in twenty-four hours. One man, passing an average of twelve ounces per diem for several days, filled up his chamber-pot in one night on two

grains administered at bedtime. I have not known the drug to produce gastric discomfort; it has been vomited, but that was where there was previously existing uræmic vomiting. It does not raise intravascular tension, like digitalis; in fact, I have not been able to demonstrate that it affects the heart in any one way or another. From my own experience, its highest usefulness has been in cases of general dropsy late in contracted kidney or mixed nephritis, when there is beginning or advanced failure of heart compensation. Here I have never seen it fail, although it has apparently done so for some of my friends. It has been less useful (although sometimes quite successful) in the dropsies from acute renal disease. This drug is well deserving of a careful study in a series of cases, and this study should include qualitative urinalyses. *No better work could be done by this Club than to make a prolonged, accurate and complete clinical study of the class of drugs known as diuretics!*

Calomel—so highly praised by Goodno and some others—have not given me a great deal of satisfaction. With even the small doses carefully administered I have salivated; and those who have had cases of mercurial stomatitis in the course of Bright's disease know what a severe affliction it is. I believe, with Andrew Smith,* that calomel will be found to have its sphere of usefulness in a certain class of purely cardiac dropsies.

Of the hydragogue cathartics, I have found elaterium and its alkaloid, elaterin, very uncertain in their action. Croton oil is of much more uniform activity. A very successful country practitioner, now deceased, used a preparation (I think infusion) of the berries of the *burning bush*† for various dropsies, and some cases which he described to me as having recovered would suggest a decided sphere of usefulness for the drug, and its possible virtues should be looked into.

As to *digitalis*, I have nothing to add to the general consensus of opinion. It always increases the cardio-vascular tension. In proper preparation and dosage, its action is often very satisfactory. The fresh infusion and Funk's fluid digitalis are the best preparations for dropsy. A favorite combination with me is Tr. Squills, ℞xv; Strophanthus, ℞v; Digitalis,

* Hare, *System of Therapeutics*.

† *Euonymus Americana*, or wahoo. The *euonymus atropurpureus*, another variety, is used by the eclectics.

mgv, every two hours until diuresis; but the patients should be watched, and the question of arterio-sclerosis and possible cerebral hæmorrhage from increased arterial tension borne in mind.

A very curiously written eclectic work which I have, highly recommends hair-cap moss infusion (drink freely) in dropsy; I have had no experience with it.

No reference has been made to the homœopathic remedies adapted to dropsical conditions, because the object in presenting this paper was to consider only the strictly palliative or medicinal therapeutics.

SHOCK IN ABDOMINAL OPERATIONS.—Turck (Chicago) recognizes the usual distinction between shock and collapse, and although his experiments do not throw any light upon the pathology of this complex phenomenon, they point out two interesting factors not yet sufficiently investigated by other experimenters. One is the decreased resistance against infection when shock is present, and the other is increased resistance against infection produced by the application of heat within the colon, stomach, or abdominal cavity. Thus it was found that even virulent cultures of staphylococci or streptococci would not develop when inoculated into the peritoneal cavity of animals, provided the heat stimulation lasted for one hour. As opposed to this, if shock were first produced by exposing the viscera to the air for a time, what are termed non-pathogenic organisms introduced into the peritoneal cavity would develop rapidly and kill the animal.

The author has also demonstrated that if the blood-serum of an animal in shock is injected into another and healthy one, symptoms of shock would be produced, even resulting in death, provided enough of the serum was used. But if an animal was first stimulated by heat applied within the splanchnic area for one hour or more, the serum of that animal injected into another produced resistance to infection amounting to a partial immunity. This would seem to establish the fact that in shock there is an alteration in the tissue cells and blood, the exact nature of which is not yet clearly understood.

The author makes use of the practical points in his experiments as follows: When shock is present it is combated by applying heat to the stomach in the following way. A thin rubber bag attached to a "double current" stomach-tube is introduced into the stomach, and about 500 c.c. of water of a temperature of 122° F. allowed to flow into it and distend the bag. The water is allowed to remain for a few minutes, then permitted to flow out. This procedure may be repeated, or a continuous flow kept up, increasing the temperature gradually to 131° F. During operations thin rubber hot-water bags covered with flat gauze sponges are introduced within the abdominal cavity, and serve the double purpose of keeping the intestines from the operative field and supplying the necessary constant heat to prevent shock. The water in the bags is of a temperature of 48° C.—*The Philadelphia Medical Journal*, March 30, 1901.

EDITORIAL.

THE NEW SCHOOL OF MEDICINE.

PRESIDENT REED, in his annual report before the American Medical Association at St. Paul, on June 4th, gave utterance to the following: "I proclaim, events proclaim, the existence of a new school of medicine. It is as distinct from the schools of fifty years ago as is the Christian dispensation from its Pagan antecedents. It is the product of convergent influences of diverse antecedent origin. It acknowledges no distinctive title, it heralds do shibboleth. It is a school of human tolerance, of personal independence, of scientific honesty. It is the slave of neither prejudice nor preconception, and abandons the accepted truth of yesterday, if it be only the demonstrated error of to-day. It places no premium upon personal prerogative, and extends no recognition to individual authority. It makes no proclamation of completeness, no pretension to sufficiency. It recognizes that truth is undergoing progressive revelation, not ending to-day, but continuing through the ages. It yields its plaudit to achievement, and recognizes that he is the greatest among men who reveals the most of truth unto men. It greets as a friend him who thinks, though he think error, for, thinking, he may think truth, and thereby add to the common fund. It heeds all things, examines all things, judges all things."

In the course of an article on "Medicine During the Last Century," contributed to the *New York Sun*, Jan. 27, 1901, Wm. Osler, M.D., of Johns Hopkins University, says: "The century has witnessed a revolution in the treatment of diseases and the growth of a new school of medicine. . . . A new school of practitioners has arisen which cares nothing for homœopathy, and less for so-called allopathy. It seeks to study rationally and scientifically the action of drugs, old and new."

In June, 1898, we wrote: "We have always regarded the name 'physician' as the ideal, and we trust a time may come

when all seekers of the truth will unite under it; but it must be upon a higher plane than that occupied at present by the profession at large."

In April of the same year we said: "A truly liberal medical spirit could only result logically in striking out of the constitution of every medical society, homœopathic as well as allopathic, every reference to the therapeutic views of its members; and with a proposition looking to this end we would be heartily in accord."

It would seem at first glance that our hopes were at last being realized; that a way had been opened for a union of all seekers after the truth on a plane above all sectarian restrictions; in fact, that there already existed a body of men actuated only by the purest scientific motives, bound together into a new school of medicine, following the highest ideals; in short, a school of "human tolerance, of personal independence, of scientific honesty."

The vision presented to our enraptured gaze is that of a medical millenium, evidences of which should surely be sufficiently clear to enable us to recognize its existence. But, alas! search as we may, such evidences are not visible. Indeed, even from Dr. Reed's address it is plain that, as at present constituted, the dominant school does not represent such a new departure as he would fain have us believe. In referring to the necessity for a revision of the rules of the Code, he says: "These, if construed to have a fundamental importance, and if rigorously enforced as they now stand, would disintegrate the Association in a single day. This reason, and others already given, confirm me in the conviction that such rules should be either amended or abrogated; or, if reaffirmed, it should be by general resolution endorsing their underlying principle but disclaiming the present applicability of their details." (Not guilty, but don't do it again.) "There are, however, various views entertained upon this subject," and he therefore recommends the reference of the general question of the revision of the rules of conduct to a special committee of three, with instructions to report at the next annual session of the Association. This new school is, therefore, by no means co-extensive with the present so-called allopathic school, nor yet even with the membership of the Association, to whom the

President extended greetings as to "the exponents of this new school, of this new generation, of this new century, as representatives of the democracy of science."

We are always loth to ascribe improper motives to a laudable action, and we hesitate to think that this heralding of a new school of scientific tolerance is prompted by anything but the actual growth of a liberal spirit; and yet, in view of some of the statements made in this address, the truth of which cannot be denied, it would seem that back of this may lie, more or less consciously, the hope that by a new policy, ostensibly most liberal, and therefore calculated to appeal to the public, the identity of a dangerous rival, homœopathy, may be destroyed, and its achievements quietly appropriated.

Referring to the period subsequent to the organization of the Association, Dr. Reed says: "The general spirit of ostracism and aloofness was manifested during the succeeding three decades. As time passed, schismatic medicine grew apace, its colleges multiplied, its practitioners appeared all over the country, exemplifying the law that always makes 'the blood of the martyrs the seed of the church.'" We thus see that the proscriptive rule which, during the more than twenty-five years of its dominance, propagated the very evils it was intended to correct, is rapidly expiring by limitation in the face of new conditions that have been induced, in spite of it, by beneficent and catholic legislation. In the State of New York alone the annual registration of sectarian physicians has diminished nearly 90 per cent. under the operation of its present laws. In the State of Ohio, many physicians who are graduates of sectarian schools are making application to have their classification in the register changed to "regular," while equal reactionary movements are observable in other States. "Thus we observe the passing of Homœopathy and Eclecticism, just as did the calm scientist of Rome witness the passing of Humeralism," etc. It does seem as if the hoped for "passing of homœopathy" and the desire to assist in the operation may have had something to do with this sudden growth of a new school.

It is possible that the members of this hypothetical new school can be compared to the "calm scientists" of Rome, and that the school is a school "of human tolerance, of personal independence, of scientific honesty," but has not always been so, nor is it even now the case.

Timeo Danaos et dona ferentes.

The rantings and ravings of the unregenerate opponents of homœopathy still echo in our ears, not only from the rank and file, but even from acknowledged leaders in the host of rational medicine. Calm dignity and scientific impartiality have ever been conspicuous by their absence from the utterances of those who always attacked, but never examined or judged, the merits of homœopathy. The human tolerance was like that shown by the Inquisition, or by the burners of the witches of Salem; the personal independence has been crystallized in their code and exemplified in the proscriptive execution of its provisions; their scientific honesty is carefully veiled in their surreptitious appropriation, without credit given, of many of the discoveries of homœopathy. (Vide "Simplicity in Therapeutics," *American Medicine*, June 1, 1901.)

But we will be answered that these are things of the past; the new school has turned over a new leaf, and is going to be, in fact already is, most peaceably and liberally inclined; all may come into it, all may work in it, all may delve, all are friends who think; even if they think error, they may perhaps hit upon a truth in their thinking, and thereby add to the common fund. There is but one condition for admission, seemingly easy of fulfilment: all must come without any certain knowledge of truth, and without the expectation of ever arriving at such; without "prejudice or preconception," "ready to abandon the accepted truth of yesterday, if it be only the demonstrated error of to-day," and equally willing, no doubt, to let to-morrow's ephemeral truth supplant to-day's. It is rather a restless sort of school, but will perhaps suit the many who love to look at the universe in a kaleidoscope, by every slightest movement of which new figures, new patterns and new combinations are made to present themselves. Is this restless uncertainty absolutely necessary to an ideal new school? We think not; and the address hedges when it says further of it, "it makes no proclamation of completeness, no pretension to sufficiency." That is the keynote, the recognition of the possibly incomplete character of truths discovered in their gradual progressive revelation. With this modification, we maintain that in homœopathy of the present day is to found the new school, the beauties and virtues of which Dr. Reed extols, but finds, without

sufficient reason or proof, particularly represented among the members of the American Medical Association. With the exception of the retention of a distinctive title, homœopathy of to-day will be found to exhibit all the characteristics enumerated by him in the extract from his address at the opening of this paper. Are we justified in retaining this title? Many think not, and have acted in accordance with their convictions. We do not think that the time has come for such action. Far from "rejecting the accumulated experience of the profession," homœopathy has learned to recognize its contradictory and delusive character as a guide in the treatment of disease, as opposed to some principle or law deduced from the rational study of this very experience. From such study Hahnemann arrived at the law of *similia similibus curantur*; and, while adopting it as a shibboleth, if you please, during the period of active warfare, homœopathy of the present day retains it as a standing protest against the crass empiricism which has been the only guide to the profession at large. It has come to recognize, however, that, according to its present increased knowledge, there are limitations to the application of this law, and that it is only a partial revelation of the truth. It says *similia similibus curantur*, and, with this as a basis for its investigations, shows itself ready and willing to accept other partial revelations, no matter by whom offered. It is the true liberal new school; and although it, too, has had its period of dogmatic intolerance, and although even at the present time in its fold, as in the old school, laggards in the march of progress are found who seek to cast discredit on the advance of unsectarian science, as a whole it proves its claim to being the free-born new school by its willingness and promptness in investigation. Compare the almost universal ignorance of homœopathy as found in the old school with the knowledge of allopathy possessed by homœopathic graduates, and there will be no hesitation in deciding of which school it can most truly be said, "It heeds all things, examines all things, judges all things."

SOME QUOTATIONS, WITH COMMENTS.

IN *American Medicine* for June 1, 1901, we find an article with the title "Simplicity in Therapeutics," by Edwin W. Pyle, M.D., Fellow of the New York Academy of Medicine, and Assistant Surgeon of the New York Eye and Ear Infirmary. This article is unquestionably as fair a presentation of many of the facts and principles of homœopathy as has ever appeared in an old-school journal. It would be interesting to offer it complete to our readers, but as it contains nothing which would be new to them, we will content ourselves with commenting upon some of its statements, which we do the more readily as it will furnish a commentary upon our remarks in regard to the new school of medicine.

Dr. Pyle, although "raised under influences which prompted relentless dosing for all ailments," would, "after thirty years of general practice, wish to leave to the rising generation of physicians the request, in the interest of humanity, to simplify prescribing in using the smallest dose and the least medicine possible to accomplish the therapeutic purpose."

This sounds familiar to our homœopathic ears, and we can only hope that in these latter days the injunction may be heeded by those for whom it is intended better than was the same, given by Hahnemann long ago, by those to whom he addressed it.

Among the opening sentences of his paper we find, "The small dose has not yet run the gauntlet of professional prejudice, but it has been championed by the people to such an extent as to become a revolutionary agent in methods, and a positive contribution to therapeutics." We are not quite clear as to the exact meaning intended to be conveyed. Surely the small dose has been running the gauntlet ever since its efficacy was asserted by Hahnemann, but unfortunately the gauntlet of the prejudice, and not the impartial judgment of the profession. Why has the small dose been championed by the people? Surely rational medicine would not allow itself to be dictated to by the unreasonable clamor of the people to

such an extent as to favor a revolutionary agency in methods, or to accept it as a positive contribution to therapeutics.

No; the people have championed the small dose because experience at the hands of homœopaths has proved its efficacy, and homœopathy, therefore, should be credited with this positive contribution to therapeutics.

The valuable "outgrowth of studying the effects of drugs upon the healthy body," insisted upon by Hahnemann, is set forth somewhat in detail by our writer, again without any credit being given where it of right belongs.

We cannot regard his attempt to explain the curative action of small doses as any more successful or convincing than various other attempts made by homœopaths. He ventures the opinion that "when a special part or organ becomes inflamed or disturbed in function, the physiologically selected medicine acts as a stimulant to restore balance of forces, when given in small or frequently repeated doses; but irritates, congests or paralyzes recuperative power, thereby aggravating the malady, when given in large doses at long intervals." He says, further, "The physiologic action of the drug may point to its therapeutic use;" and, "whenever it is possible to apply the stimulating influence of the physiologically indicated dose, prescribing becomes ideal; relief is not wrought at the expense of other organs, as is the case when syrups are given for coughs, nor is the physician's mind tormented by a senseless and unreliable symptomatology." Had the gentleman been conversant with homœopathic literature he would have known that very many, if not all, of the indications for the use of the remedies he recommends in small doses have been derived from a study of this same senseless, unreliable symptomatology.

He evidently takes for granted that his readers know that the physiologically indicated remedies are applied according to the homœopathic law, to which, however, he only refers to say that the facts enumerated "constitute no foundation for a belief in small doses only, or in the universality of a law of cure." Had Dr. Pyle kept abreast of the progress of the homœopathy of the present day, he would know that the *absolute* size of the dose no longer plays the prominent part that it did in the first reactionary period of the existence of our school, but that we are perfectly in accord with his own statement that "The sin-

gle remedy, hygienically (physiologically?—ED.) given, *in whatever dose* (the italics are ours.—ED.), not only simplifies prescribing, but is scientifically correct.”

He would also have learned that in the evolution of our art the application of the law of cure has been found to have its limitations, some of them natural and necessary, others resulting from imperfect knowledge of its true scope. He would further have become acquainted with the efforts that have been made, and are being made at this time, to revise our *materia medica*. This, while it will ever remain a monument to the genius of Hahnemann, is acknowledged to have many faults inseparable from a first effort in an entirely new field. Homœopathy has not stood still. Only a small minority of homœopaths of the present day are content to wrap the legacy left by Hahnemann in the napkin of reverential indolence; the majority are seeking to put it out at interest for the benefit of themselves and mankind. But enough comments have been made, we think, to show that Dr. Pyle is not far from the kingdom of Homœopathy, and that all which is wanting to make him a member of the true new school of medicine is the courage of his convictions and the willingness to acknowledge their original source.

THE TREATMENT OF THE CORD IN THE NEW BORN.—(Stolz.)—Ahlfeld tested three methods in fifty cases each.

1. Ahlfeld's; consisting in secondary ligation, cleaning with alcohol, and a permanent cotton dressing.

2. Martin's; tying the cord with silk close to the umbilical ring, cutting the cord with cautery scissors, and a cotton dressing changed daily.

3. Grazer's; which is like the latter, except that the cord is cut with sterile scissors instead of the cautery.

In all cases the daily bath is omitted till the stump of the cord falls off. A considerable amount of gauze is used over the stump to keep it dry and to prevent infection. The experiment showed about the same results in the first two methods, except that mummification was more rapid in Martin's and the navel healed more quickly. The second ligature should not be applied sooner than an hour or an hour and a half after birth, so as to give time for the cord to collapse. The writer advises, therefore, Martin's method when practicable, careful asepsis of the cord and ring; a very short stump, the second ligature being applied after the cord has collapsed; the use of a thin tape or silk for ligature; covering the stump with some dry antiseptic powder; the use of a considerable amount of sterile gauze for a covering; this dressing is to be kept dry and not changed until the stump has come off, *i.e.*, after the fifth day.—*Centralblatt für Gynaekologie*, No. 11, 1901.

GLEANINGS.

OCULAR DISTURBANCES CONSECUTIVE TO THE USE OF THYROID PREPARATIONS.—While thyroidine has occupied a well-deserved place in the therapeutics, it has its dangers. We know that there is such complication as *thyroidism*. Dr. Coppez, of Brussels, observed in four cases out of five, all of whom were females, that the prolonged use of thyroid preparations for obesity produced very grave optic neuritis, with lesions of the papula more marked than in cases of alcoholic or tobacco intoxication. Amblyopia manifested itself only after several months of use of the drug, but once declared, the ocular affection has run, in a rapid manner, and in six weeks or two months the eyesight fell to 1/10, or still lower. When the administration of the thyroid is suspended, the neuritis first remain stationary, then get better and disappear. But the retinal vessels are involved, a long treatment becomes imperative to obtain a satisfactory result. In certain cases, thyroidism may exclusively become manifest by the existence of a partial retrobulbar optic neuritis with scotoma centralis. Dr. Vennemann, Prof. of Ophthalmology at the Medical Faculty at Louvain, Belgium, observed in two young girls, after the use of thyroid extract tablets, accommodative asthenopia. The medicine being stopped, ocular troubles soon disappeared.—*L'Art Medical*, April, 1901.

OVARIAN OPOTHERAPY IN ANGINA PECTORIS DURING MENOPAUSIS.—Dr. Th. K. Geissler, privatdocent of medicine in the Military Academy of Medicine of St. Petersburg, admits that during menopauses there occur attacks of true angina pectoris, without depending upon the sclerosis of the coronary arteries. These attacks are not the *angor pectoris* observed in neurasthenics and hysterics. The attacks occurred in critical age, being repeated every month when patients used to have their courses, and were not influenced by narcotics. Ovarian extract being administered, the attacks ceased, although temporarily, for as soon as the remedy was discontinued, attacks of angina pectoris recurred, but the administration of the ovarian extract rapidly checked the paroxysms.—(*Semaine Medicale*, 9 March, 1900), *L'Art Medical*, April, 1901.

John Arschagouni, M.D.

ORAL SEPSIS AND PERNICIOUS ANÆMIA.—Hunter, in a paper read before the West London Medico-Chirurgical Society, offers a summary of his interesting view as to the relation of oral sepsis to pernicious anæmia. He had, he stated, investigated the latter disease for some fifteen years, and had arrived at the following definite conclusions :

1. As regards its nature, the disease is not merely a specialized form of anæmia, but a definite and well-characterized special infective disease localized to the mucosa of the alimentary canal, and one in which sepsis, both oral and

gastric, appears to play an essential part. It is accompanied by definite infective lesion of the mucosa, difficult to find post-mortem, but characterized when observed during life in the mucosa of the tongue as a glossitis. This is not the result of the anæmia, and is very persistent, coming and going, when once established, in a most remarkable manner and independently of any cause. This unhealthy condition of the mucosa is due in the first instance to long-standing oral and gastric sepsis, the result of suppurating and necrosed teeth, and this condition permits special infection to occur.

2. The typical mode of development is as follows: A history of oral, gastric or intestinal trouble extending over many years without any anæmia, more or less suddenly followed by an anæmia out of all proportion to the severity of the symptoms, and denoting the supervention of a new factor, viz., increased hemolysis dependent upon a new and special infection of the alimentary canal. On inquiry it will generally be elicited that at or about the commencement of the anæmia the patient suffered from sores or lesions of the tongue. Experience lends no support to the view that ordinary anæmia-producing factors, if only severe enough, can give rise to this form of anæmia, and cases of the kind can be successfully excluded, not only during life, but still more easily after death, by the absence of the clinical features and anatomical changes which are found to characterize the disease.

3. Anæmia is only one of the symptoms of this disease, and there are at least three other groups of symptoms, viz., hemolytic, oral and gastric, and intestinal and toxic symptoms, these being caused by the infection which lies at the root of the disease, and being more or less pronounced in every case of pernicious anæmia. They have one factor in common, viz., their periodicity, variations in the severity of the symptoms being common from week to week, corresponding with the activity of the infected process. By these symptoms the disease can be diagnosed with certainty during life, and after death by the no less characteristic pigmentary changes in the liver. With regard to treatment, strict antisepsis both of the mouth and of the gastro-intestinal tract must be repeatedly carried out. Arsenic and iron supplemented in suitable cases by anti-streptococcal serum injections are found to be useful.—*Lancet*, May 18, 1901.

F. Mortimer Lawrence, M.D.

LEUCOCYTOSIS IN TYPHOID PERFORATION.—Russell, as the result of observations made in the Montreal General and Royal Victoria Hospitals, draws the following conclusions:

1. In perforation leucocytosis is the rule, but it varies widely.
2. It usually appears early, but may not be marked until general peritonitis and collapse have supervened.
3. It may be absent in marked perforation and peritonitis—in fact, the number of leucocytes may be below normal.
4. Typical signs of perforation and leucocytosis may be present without any such complication; and
5. If abdominal pain and tenderness come on suddenly, and if in the absence of other symptoms there is distinct leucocytosis, even without other signs of perforation, operation is justifiable and may be advisable.—*Boston Medical and Surgical Journal*, April 18, 1901.

F. Mortimer Lawrence, M.D.

EOSINOPHILIA IN TRICHINOSIS.—Sears, of Boston, records a case of trichinosis, the most interesting feature of which was a blood count showing 16,200 leucocytes, of which $17\frac{1}{2}$ per cent. were eosinophiles. Later accounts carried the percentage of eosinophiles as high as 39 per cent. This case is the twenty-fifth which has found its way into literature since the discovery at the Johns Hopkins Hospital of a marked eosinophilia in trichinosis. All have been reported by American observers, and all have confirmed the first observation, with the exception of a fatal case reported by Howard, in which no differential count was made ante-mortem. An increase of the eosinophilic cells has been found as early as the fifth day, the earliest on which a count was made, and in a case reported by Stump they still composed 15 per cent. of the whole at the end of four months.—*Boston Med. and Surg. Journal*, June 6, 1901.

F. Mortimer Lawrence, M.D.

THE INDICATIONS FOR SURGICAL TREATMENT OF GASTRIC ULCER.—Lund, of Boston, summarizes the indications as follows:

1. In perforation immediate operation is absolutely indicated.
 2. In cases in which the symptoms fail to yield after medical treatment for a reasonable period, operation, consisting either of excision of the ulcer or gastro-enterostomy, should be performed, and this before the patient has become so exhausted as to render surgical intervention dangerous.
 3. In hæmorrhage, where slight, frequently repeated bleeding promises to produce grave anæmia or exhaustion, similar early operation should be done.
 4. Where a patient has suffered more than one copious hæmorrhage operation should be performed, and the extent and nature of the procedure should be decided upon according to the power of the patient to withstand operative manipulations, and the conditions found during the progress of the operation.
- Boston Medical and Surgical Journal*, June 6, 1901.

F. Mortimer Lawrence, M.D.

HEART AND CIRCULATION IN FEEBLE-MINDED CHILDREN.—The conclusions reached in a study of 72 cases are: (a) In a great number were found cardio-vascular defects, out of proportion to the mental defects. This was so well marked as to assume organic vascular heart disease to be a very large etiological factor in the continuing of the downward course of imbeciles. (b) A careful study is urged of the body, other than that of the nervous system, in cases of mental enfeeblement. (c) Many of the high-grade class can be bettered much more by attention being paid to the therapeutics of cardio-vascular disorders. (d) The action of certain alkaloids upon the peripheral circulation needs careful study and experimentation. (e) The proper use of well-regulated movements, for imbeciles are good imitators, will greatly help, not only in physique, but in mental power. (f) The use of over-exercise is to be condemned, especially on account of the cardio-vascular-condition.—*American Journ. of Med. Sciences*.

William F. Baker, A.M., M.D.

ETIOLOGY OF YELLOW FEVER.—The conclusions reached from the investigations are:

- (a) The mosquito (c. fasciatus) serves as an intermediate host for the parasite.
- (b) Yellow fever is transmitted to non-immune by the bite of the mosquito that has previously sucked the blood of one sick.
- (c) An interval of about 12 days seems to be necessary before the animal can convey the infection.

(d) The bite of the mosquito earlier than this period does not appear to confer any immunity against a subsequent attack.

(e) Yellow fever can be experimentally produced by the subcutaneous injection of blood taken from the general circulation during the first and second days of the disease.

(f) An attack of fever produced by the bite of the mosquito confers immunity against the subsequent infection of the blood of an individual suffering from the non-experimental form of disease.

(g) Period of incubation of experimental cases is from 41 hours to 5 days.

(h) Yellow fever is not conveyed by fomites; hence the disinfection of clothing, bedding, etc., is not necessary.

(i) A house may be said to be infected when there are on its walls contaminated mosquitoes.—*American Journ. of Med. Sciences.*

William F. Baker, A.M., M.D.

TREATMENT OF GASTRIC ULCER.—The prime object is to give the stomach rest, in order to promote cessation of its motor and excretory functions. Cicatrization is aided by administration of antacids to neutralize gastric secretion. Patient must be confined to bed. For a period of one or two weeks the patient is to be fed solely by bowel. All food is to be withheld. Thirst is overcome by small particles of cracked ice. Rectal feeding is to be instigated after the bowels have been relieved by calomel, and later an enema, although persistent vomiting and hæmorrhage contra-indicate this. *Feeding* should be given every 8 hours. Five to 7 hours' retention of enema is all that may be expected. The bowels should be flushed before each feeding, followed by enema of salt solution, and after $\frac{3}{4}$ hours the nutritive enema is given.

Composition of Enema.—One heaping teaspoonful of concentrated albumen, dissolved in a little water; one large egg thoroughly whipped; peptonized milk, 4 ounces. The temperature of the enema should be slightly above the normal body temperature.

Local Treatment of Ulcer.—The stomach-tube should be used with the greatest care. The administration of silver by the mouth is useless. The greatest benefit is to apply in the following manner: The stomach is first washed with unmedicated water; then 500 c.c. of a solution 1 : 1000 silver nitrate is passed into the stomach, and withdrawn after a few minutes. The stomach is immediately washed with warm or cool water, until the washing shows no color of the silver chloride. Application is made every third day. After washing, a teaspoonful of bismuth subnitrate is introduced, in 4 ounces of water.

In cases of debility or recurrent hæmorrhage, the bowel treatment is omitted during the period of bowel feeding. Hot or cold compresses to the epigastrium; heat after hæmorrhage, or use of coil in which either hot or cold water may be used.

In control of hæmorrhage, the writer points out that the use of ergot is liable to make bleeding worse. Hydrastinine hydrochlorate (grs. $\frac{1}{4}$ to 1) hypodermically every 2 or 3 hours. *Hypodermoclysis* should be resorted to in cases of profuse hæmorrhage.

Subsequent mouth-feeding should be begun very cautiously, and not until one week after the acute symptoms have subsided.—*Therapeutic Gazette.*

William F. Baker, A.M., M.D.

A CLINICAL STUDY OF 500 CASES OF CROUPOUS PNEUMONIA.—Perhaps the best way of understanding diseased conditions is the drawing of conclusions from a large number of cases observed well. From the clinical study of these cases we learn that the general mortality was 25 per cent. Males seemed to have been attacked in larger numbers than females. The greatest mortality was seen in drunkards, it being there about 67 per cent. Advanced age claims a large percentage, and early life a comparatively low percentage of mortality.

Site of the Lesion.—The right lower lobe was affected in 145 cases, the left lower lobe in 115 cases, both bases in 60 cases, right apex in 55 cases, whole right lung in 45 cases, whole left lung in 35 cases, left apex 20 cases, both apices 4 cases, right middle lobe 14 cases. The frequency of apical pneumonia in infancy is noted, and also between the ages of 20 and 30.

Temperature.—The maximum temperature for the greater number of cases was 103°. The afebrile cases were few. The table illustrating the mortality from the different temperatures illustrates the fact, clinically well known, that the highly febrile cases are not to be feared as much as the asthenic ones, because the former is an index of the patient's resistance. However, the exceedingly high temperatures are shown to be dangerous.

Chill in onset was observed in one-half of the cases.

Termination of the Fever.—A crisis was observed in 300 cases. The majority of crises was observed in 74 cases. The crises occurred from the 6th to the 10th day, the majority being observed on the 8th day. The latest day in which a crisis occurred in an uncomplicated case was the twenty-second.

Urine.—The majority of cases showed some disturbance in the kidneys, and of the fatal cases only 12 showed no trace of kidney lesion.

Complications given in order of greatest number of cases: Jaundice, delirium tremens, typhoid fever, pleural effusion, phthisis, nephritis, empyema, malaria, endocarditis, pericarditis, meningitis, erysipelas, gangrene of the lung, peritonitis.

Pupils.—In the examination of 64 cases, the pupils were large in 33 of the cases, and inequality found in 2.—*American Journ. of Med. Sciences.*

William F. Baker, A.M., M.D.

SLEEPLESSNESS IN HEART DISEASE AND ITS TREATMENT.—This symptom must always be of serious moment, especially when uncontrolled. Opium and morphia are among our best, especially in the presence of pain.

Chloral hydrate should only be given when the tension is high and its depressant action on the heart is beneficial, as in alcoholics.

Trional has no action on the circulation or respiration, hence it can be used in any form of heart disease. If much prostration is present, as after grippé, its use should be avoided.

Paraldehyde is useful, but not in the presence of dyspeptic conditions.

Chloritone is one of the most useful for its quiet action and for the fact that it is not depressing.

Alcohol will in many cases promote sleep before heart failure has advanced far. It should be given in small doses, as the patient is settling down to sleep. If tension be high, it will aggravate the condition.—*Clinical Journal.*

William F. Baker, A.M., M.D.

THE TREATMENT OF INCARCERATED RETRODISPLACEMENTS OF THE PREGNANT UTERUS.—(Seeligman.)—The writer reports that, in difficult cases,

the displacement has been overcome by pulling down vigorously on the cervix uteri with volsellum forceps and a little to one side of the pelvis; at the same time making gentle pressure under the fundus toward the pelvic brim, in the diameter opposite to the pole occupied by the cervix. This manœuvre brings down the uterus and rotates the fundus uteri from under the projecting promontory into a long, oblique diameter of the pelvis, and is performed with the patient in the knee-elbow position.

The next step, if reposition is not effected already, is to place a colpeurynter under the fundus and fill it with fluid, to maintain an elastic pressure; the patient during this period lies on her side, or the pelvis can be elevated.

In a few hours the colpeurynter can be removed and the manœuvre repeated, if necessary. After the uterus is replaced completely, a Hodge pessary or a Mayer's ring can be worn for a time, to insure retention.—*Centralblatt für Gynaekologie*, No. 5, 1901.

George R. Southwick, M.D.

DISINFECTION OF THE HAND IN OBSTETRICAL PRACTICE.—(Strassman.)—Lysoform has excellent antiseptic properties for this purpose, as it leaves the hands smooth and slippery. The use of fats in pre-antiseptic times, if free from infecting germs, afforded some protection to the patient when thoroughly and thickly smeared over the hands. In the Royal Charité Maternity of Berlin, the examiner is required to smear the hand and finger with a thick layer of byrolin, which acts in a way which can be compared to a sterilized rubber glove between the hand and the vagina, and the sense of touch is not diminished. In septic cases, the operator should protect himself with rubber gloves.

Germs entering wounds are not meeting the same conditions as in culture-tubes. The cells and fluids of the tissues possess in themselves antitoxic properties which must be considered. The ideal antiseptic must be a powerful germicide, and yet one which preserves to the utmost the natural conditions and physiological functions of the cells and tissue. Clinical results are influenced unfavorably by very long operations, compression of tissue, oozing in the wound, accumulation of fluids in the wound, poor drainage from large cavities and surfaces, etc.—*Centralblatt für Gynaekologie*, No. 11, 1901.

George R. Southwick, M.D.

THE CAUSES OF PRECLIMACTERIC HÆMORRHAGES.—(Theilhaber.)—These often find their origin in malignant disease of the uterus, endometritis, polypi, new growths, salpingitis or ovaritis, but there are some cases in which these causes will not explain the source of the hæmorrhage. The writer believes the cause lies in an abnormal condition of the uterine muscle. Atony of the uterus in older women often depends on the fact that there is an excessive growth of the connective tissue, and the muscular tissue is correspondingly reduced. It is a part of the retrograde metamorphosis of the genitals. Reinicke examined microscopically four uteri removed for metrorrhagia from women of 40–45 years of age. There was a marked excess and growth of the intra-muscular and perivascular connective tissue. In some places the bundles of muscle fibre were not only diminished, but degenerative processes were present.

Nearly all authors agree that in the uteri of old women there is diminution of the muscular and increase of the connective tissue, and many of these

writers believe that the process is due to atheromatous changes in the blood-vessels and the latter cause the hæmorrhages. The writer does not accept this last view of the cause of hæmorrhage, but is of the opinion that the diminution of the physiological functions of the muscle fibres is a normal condition about the fortieth year, and is a part of the general retrograde metamorphosis of the genitals, a diminution of the function of the uterus, even the diminished power to expel the product of conception. The unused muscular fibre atrophies and obliterates many of the uterine vessels, the two conditions being co-ordinate and both caused by physiological anæmia of the genitals with advancing years. The preclimacteric hæmorrhages are explained by the atony of the uterine muscle and bear some analogy to the menorrhagia of puberty. The connective tissue preponderates over the muscular tissue in the uterus of a young girl, which is the reverse to that found in the adult woman of twenty. If the development of the muscular fibre and the formation of the uterine blood-vessels do not keep pace through puberty, and the former is tardy, then menorrhagia occurs, also chlorosis, phthisis, etc.

There is not infrequently a rapid growth of a fibroid in the preclimacteric period similar to that of pregnancy, which is due to the hyperæmia depending on the atony of the uterus. After the termination of the menopause, the tumor diminishes rapidly, as after the puerperal period. The so-called endometritis fungosa is also a frequent secondary development caused by hyperæmia from insufficient contraction of the uterus, which explains its frequent recurrence after curettement.—*Archiv für Gynaekologie*, Bd. 62. H. 3, 1901.

George R. Southwick, M.D.

SOME FORMS OF COMPLICATED APPENDICITIS.—Kelly (Baltimore) suggests some methods of procedure that may be resorted to in best removing densely adherent appendicitis. When the adhesions are near the tip it may be found convenient to detach the appendix at its base, thus freeing it from the cæcum, and then peeling it out, in the meanwhile protecting its cut end by wrapping it up in a small piece of gauze. This plan applies especially when the appendix is attached to a pyosalpinx, or an ovarian or fibroid tumor, thus allowing it to be enucleated with the tumor or the pelvic abscess. When strong old adhesions are encountered which completely bind down the appendix, it may be removed with the least amount of damage by detaching its base, lifting the free end by a pair of forceps; circumsise it just below the forceps, thence carrying the incision down the dorsum of the appendix as far as it is visible, cutting through the peritoneal and external muscular coats. The entire mucosa with the circular muscular coat is "skinned" out, leaving the longitudinal coat behind. There is very little or no bleeding. This method has also been successfully used by Mixter, of Boston.

When the end of the appendix enters an abscess-cavity surrounded by adherent intestines which cannot be stripped off, it is sometimes of use to sever the appendix at its base, then split it open, and by following the lumen with a grooved director, the abscess-cavity may be entered, laid open and sterilized without doing any damage to the intestinal coils.—*American Medicine*, April 20, 1901.

Gustave A. Van Lennep, M.D.

THE OPERATIVE TREATMENT OF CIRRHOSIS OF THE LIVER.—Frazier (Philadelphia) reports the following successful case: a laboring man of

middle life, with a history of syphilis eighteen years before, and a free user of alcohol and tobacco. Liver and spleen both enlarged, abdomen greatly distended with fluid, and lower extremities oedematous. Had been tapped four times, at intervals of two weeks, removing respectively 512, 485, 330 and 400 fluid ounces. The abdomen was opened in the median line, under local anæsthesia, changing to ether narcosis on account of the pain of manipulation. The parietal peritoneum on either side of the incision was rubbed vigorously with gauze pads, and the omentum, which was much thickened and contracted, sutured to the margins of the wound and the abdomen closed. Subsequently it became necessary to tap twice; 328 fluid ounces being removed on the thirteenth day and 96 fluid ounces on the thirty-sixth day. From that time there has been no reaccumulation of fluid.

The author recommends that the peritoneum of the adjacent surfaces of the diaphragm, liver and spleen be scarified with a blunt curette sufficiently to insure adhesions between the opposed surfaces. The omentum is sutured to the parietal peritoneum for a distance of three or four inches, the fluid evacuated and the wound closed without drainage.

The chief indication for the operation is the presence of ascites, due to obstruction of the veins of the portal system from cirrhosis of the liver. Absence of functional activity of the liver is an absolute contra-indication to the operation. Internal medication, particularly iodide of potash and paracentesis, should be tried first, and the operation reserved for those cases which they fail to relieve. Up to the present time there are records of but fourteen cases in literature. Of these, six cases are excluded on account of errors in technique or diagnosis and contra-indications for the operation. Of the remaining eight cases, none died, one was living and improved, and six were living and free from ascites at periods of from three to twenty-six months.—*Annals of Surgery*, June, 1901.

Gustave A. Van Lennep, M.D.

DISCUSSION ON ORGANOTHERAPIA IN DISEASES OF WOMEN.—Dr. John B. Shober.—The mammary gland of the sheep controls menorrhagia and metrorrhagia and stimulates the uterus to contract. It is indicated in all conditions of subinvolution.

The parotid gland, given throughout the intermenstrual period, will relieve dysmenorrhœa due to ovaritis, and is indicated in cases uncomplicated by chronic inflammatory disorders. The mammary gland seems to act only upon the muscle tissue. The thyroid acts upon the epithelium and the connective tissue, as shown in myxœdema, cirrhosis, and many skin diseases.

Dr. H. A. Hare.—One type of diabetes mellitus can be much benefited or cured by pancreatic extract, but the vast majority of cases are not benefited at all. Too much reliance must not be placed on these remedies.

Dr. J. M. Baldy.—The field of application of the serum-therapy (animal extracts) is very limited. Thyroid extract has been given in hæmorrhage as a last resort, and with astonishing results, once or twice, in multiparous women. He begins with 3 grains and gradually runs up to 5 grains three times a day.

Dr. Russell has used the suprarenal extract with most gratifying results in a patient who had been under treatment for nine months for renal epistaxis. From the injection of half an ounce of 10-per-cent. solution the hæmorrhage was arrested in a few hours and there was no return for nearly three months.

Dr. E. E. Montgomery has employed the thyroid extract in some cases with marked value. It is a well-known fact to breeders of animals that an animal which takes on fat rapidly is not a good breeder. So it is in women; where there is a large amount of fat, metabolic changes take place in the ovaries. Such women cease to menstruate freely, and such patients are very likely to be sterile. The administration of remedies, such as the thyroid, which bring about the decrease of fat, and cause changes in the condition of the ovaries, will result frequently in the occurrence of pregnancy. The thyroid extract has a marked effect upon the epithelial and glandular tissues. This is evident from the influence it has in decreasing the amount of bleeding which takes place from the uterus when women are inclined to bleed freely, and I have learned to have a certain amount of confidence in this drug in the irregular bleedings in women near the climacteric, in which there is no other sign of malignant degeneration. It also allays pain. Dr. Coover, of Harrisburg, also speaks of its influence in allaying the severe pain of cancer of the uterus.

Dr. Geo. E. Shoemaker has been told by a physician having a very large gynecological practice that he has used mammary extract to stop hæmorrhage with a great deal of satisfaction.

Dr. John G. Clark has prescribed parotid gland in a large number of cases of dysmenorrhœa without benefit. He has seen apparently good results from ovarian extract.

Dr. J. M. Fisher.—At the Jefferson clinic we have used the thyroid extract as well as the ovarian extract. We are convinced that thyroid extract has an influence in reducing weight. Reduction of weight in one case of amenorrhœa was followed by a return of the menses. Cannot recall a case of any result from ovarian extract, except in one case of climacteric symptoms following castration, attended by frequently recurring abdominal and pelvic pains.

Dr. John C. Da Costa.—His experience has been confined chiefly to the thyroid extract, and the results have been pretty uniform. The cases have been fibroids that refused operation. In the three cases reported some time ago the tumors reached about to the umbilicus and were tied down in the pelvis, producing bladder and bowel symptoms. The patients absolutely refused operation and were put on thyroid extract in 5-grain doses. In each case there was marked dizziness and weakness following the use of the extract, which disappeared on the administration of *nux vomica*. The tumors diminished in size, hæmorrhage ceased in a short time, and the patients were comfortable. There has been a marked diminution in weight, especially in very fat women.—*The American Gynecological and Obstetrical Journal*, March, 1901.

George R. Southwick, M.D.

THE CAUSE OF INFLAMMATORY RHEUMATISM.—The proceedings of the Nineteenth German Congress for Internal Medicine were enlivened, according to the report in the *Philadelphia Medical Journal*, May 25, 1901, by an active discussion between the Vienna and Berlin schools as to whether acute inflammatory rheumatism is caused by staphylococci and streptococci in general or by a specific organism. Meyer, of Berlin, took the field to defend his diplostreptococcus as a specific organism. He described his experiments, and emphasized the connection between the affection of the tonsils and rheumatism. He has found his organism in 12 cases of angina which led to or

accompanied articular rheumatism. Injection of the organism produced typical joint affections, and he obtained the coccus from the infected animals. Menzer, of Berlin, also opposed the Vienna investigators, and claimed that he and Meyer have for the first time experimentally caused multiple arthritic rheumatism, with the subsequent endocarditic affection. Singer, of Vienna, on the other hand, reported five cases of acute arthritic rheumatism and two cases of chorea rheumatica. In all cases of polyarthritis and in one of the cases of chorea he obtained from the joint fluids, as well as the different organs, pure cultures of the streptococcus pyogenes, which could also be found microscopically in the tissues. In the case of chorea with purulent inflammation of the joints, following an angina follicularis, he found pure cultures of the staphylococcus pyogenes aureus. He then criticised the publications, from the Berlin school, of Westphal, Wasserman, Malkoff and Meyer, who claim to have found organisms with specific characteristics. Singer claims that it is impossible, from the standpoint of bacteriology, to conclude that a micro-organism which shows but small variations of growth, etc.—variations which are common to the whole class of the streptococci—is a specific organism. Nor can the experiment be considered positive proof, since it is a well-known fact that inflammations of the joints can be caused by different streptococci.

F. Mortimer Lawrence, M.D.

TREATMENT OF DETACHMENT OF THE RETINA.—Sträkle, in his inaugural thesis, gives an account of the treatment of twenty-three comparatively recent cases of the disease by sub-conjunctival injections of salt solution. In ten cases there was a marked improvement, with complete restoration of the detached membrane in three. In nearly all (twenty-one) improvement of vision set in; in seventeen there was an enlargement of the field of vision. As might have been expected, the more recent the detachment, the more marked was the improvement. The operator began usually with a weak 2-per-cent. solution, but finally employed a 4- and even a 10-per-cent. solution. In many instances the last strength seemed the most effective.

The author thinks that the exsmosis and endosmosis set up by the salt solutions reduces the amount of the sub-retinal fluid without decreasing the vitreous mass, thus permitting the retina to resume its normal position. There is, at least, one consideration not to be lost sight of in this connection. In choosing a form of treatment for detachment of the retina, this plan has the advantage of being without risk—which cannot be claimed for procedures like the Schoeler and Deutschmann methods.—*Ophthalmic Record*.

William Spencer, M.D.

THE TRAINING OF SIGHT.—Lord Wolseley having lately remarked upon the good sight of the Boers as one cause, at least, of the good shooting, and having ascribed this good sight to its constant exercise in the open air, Mr. Brudenell Carter has pointed out that it is not merely a question of open air, but of the training of sight upon things that are far off and difficult to see.

The defective vision possessed by so many children who have been brought up in towns is not caused by errors of refraction alone, common as these are, but by an actual deficiency in acuteness of vision, a lack of development in the nervous structures involved in the act of seeing.

Vision, like every other nerve function, must be cultivated for the attain-

ment of a high degree of excellence. The visual power of city children is not cultivated by their environment. They see the other side of the street in which they live, and the carts and omnibuses of the thoroughfares.

They scarcely ever have the visual attention directed strongly to any object which it is difficult to see or which subtends a visual angle approaching the limits of visibility; and hence the seeing function is never exerted to anything like what should be the extent of its powers.

With a country child the case is widely different.—*Medical Review of Reviews.*

William Spencer, M.D.

FURTHER EXPERIENCE WITH ATROPINE IN OBSTRUCTION OF THE BOWELS. —In the German medical journal, the *Muenchener Medicinische Wochenschrift* No. 17, 1901, there are a number of articles on the use of atropine in ileus. Three of these are favorable and the fourth the contrary. At all events atropine is worthy of a trial in this serious condition before attempting to operate. Unfortunately the excessive doses required may give rise, as is noted in the fatal case, to delirium marked with great restlessness, which may have an undesirable effect on the condition of the patient after operation. The following is a fair example of a typical case: the patient, an architect of fifty-eight years, was suffering from symptoms of ileus, vomiting of fecal matter, pulse 128, temperature 36.8°, great tympanites, no detectable hernia; in his urine there was a slight trace of albumin, a positive one of indican and bile-pigments, no sugar; acid in reaction. The patient was a hemophiliac, suffered at times from constipation, and had had hæmorrhages from either kidneys or bladder as well as serious subcutaneous effusions of blood. No history of alcoholism nor syphilis. Had never had Werlhof's disease nor rheumatic purpura. On account of his collapsed condition he received three injections of camphorated oil at once. Though his stomach was washed out and two high colonic irrigations were given, one in the dorsal and the other in the knee-elbow position, no stool was obtained. Nothing was to be made out in any organ; his rectum was free from tumor and intestinal obstruction from new growths; strangulations, volvus and hernia to be excluded. An operation was thought inadvisable on account of hemophilia.

Hypodermatically 1, 1½, 2½ mgms. of atropine were given during two days. He became greatly pale, unconscious, and fell into a stupid state with low delirium and a good pulse. Temperature 37.0° in the morning, in the evening, 37.3°. Pulse in the morning 114, in the evening 100. Success promptly followed, for at first hard and then thin stools were passed. He felt well, and in a few days was discharged. He has since remained well.

Frank H. Pritchard, M.D.

PARENCHYMATOUS NEPHRITIS DURING THE COURSE OF A LATENT TUBERCULOSIS. —Dr. Labbé related to the Société Médicale des Hôpitaux of Paris the case of a young man of twenty-three who had been affected for four months with slight œdema of the eyelids and ankles, together with cramps in the limbs, etc. Examination of the urine revealed a great quantity of albumen. Renal permeability was found normal by means of the methylene-blue test and by different methods of cryoscopic examination. An injection of a tenth of a mgm. of tuberculin having been made and a positive reaction obtained, as tuberculosis was thought best to be excluded, sometime afterwards

râles were detected in the apices and the bacilli of tuberculosis were found in his sputa. The disease was therefore a parenchymatous nephritis of tuberculous origin. The interest in this case is in the feature that the parenchymatous nephritis was for a long time the only manifestation of a latent tuberculosis. *La Semaine Médicale* No. 19, 1901.—(Prof. Lépine, of Lyons, several years ago called attention to albuminuria being at times a premonitory system of pulmonary tuberculosis—pretuberculous albuminuria as he named it. I remember to have found persistent albuminuria in a negro with tuberculous cervical glands undergoing suppuration. He had become tuberculized, to use Lépine's words.)

Frank H. Pritchard, M.D.

TREATMENT OF MALIGNANT PUSTULE BY HYPODERMATIC INJECTIONS OF A CONCENTRATED SOLUTION OF IODOFORM IN ETHER.—Dr. Lidmanowski, in a patient with a malignant pustule of the back of the neck, after failure of a carbolic-acid solution injected hypodermatically and applied locally, cauterized the area with the thermocautery. In spite of this, the local and general symptoms increased in intensity. He then injected twice a hypodermatic syringeful of a concentrated solution of iodoform in ether about the lesion. The next day the patient was somewhat better; therefore, he repeated the injection, giving only one syringeful. The disease thus being easily brought under control by this measure, he tried it in another case, with fully as good results. Thus favorably influenced, he tried it in twenty-six cases of the disease, and can only praise the method.—*Przegląd Chirurgiczny*, tom iv., zeszyt 4, 1901.

Frank H. Pritchard, M.D.

THE PROGNOSIS OF AORTIC ANEURYSMS.—Prof. Kotowtschikoff advises in the treatment of aortic aneurysms an extensive use of the iodides and mercury, and especially the iodide of potassium. for a very large number of patients with aneurysms have been found to have had syphilis. With these measures one is able to give a more favorable prognosis than is generally given. The iodide should be given for a long time and in as large doses as possible. For example, he mentions one patient who from March 10th to September 12th, with interruptions, received seven hundred and fifty gms., and the following year, from the beginning of January till March, he took four hundred gms. Schmidt in the course of a year had one patient who took two thousand five hundred gms. Many patients soon develop iodism. He advises continuing the drug when the symptoms of overdosing vanish of themselves; only, if they become serious, one may leave the remedy off for a time. Some patients do better if phenacetin be administered at times on account of iodism. The beneficent action is first manifested by a relief of the pains and dyspnoea; one patient would awaken every night with dyspnoea whenever he did not take the iodide of potassium. At the same time mercury is also given, though a favorable action may be obtained from the iodide alone. Improvement is quite frequent under this treatment and cures are by no means rare. Kotowtschikoff, who has brought about recoveries thus, thinks that the outlook is better in aortic aneurysms than is generally stated, if only one can get the patient to take the iodide; if an earlier diagnosis by skiagraphy be possible the prognosis will be still better.—*Hospital-Studente*, No. 11, 1901.—(Gairdner's article on aortic aneurysms in Albutt's System of Medicine goes into this method of treatment quite thoroughly).

Frank H. Pritchard, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

NATRUM MURIATICUM IN INSANITY.—Dr. W. E. Taylor, Superintendent of the Illinois Western Asylum for the Insane, has found this remedy beneficial in cases of insanity resulting from *overheating in the sun*. Cases of many years' standing have been materially benefited, and 10 per cent. have been apparently cured by this remedy. It acts best where the secretions are morbid, bowels torpid, tongue flabby and white, skin sticky, scalp dry, hair lustreless and nails dead and ragged. The patient may be melancholy and stupid, or irritable and ugly; he is usually dejected, sits with his head down, never speaks unless spoken to, except when talking to himself, which he does quite often, owing to hallucinations. The *Natrum mur.* patients usually have hallucinations of hearing, and quite often have delusions. Their conversation is disconnected; memories are poor, minds are weak, and they seem to be confused. When spoken to, they will look at you some time before answering. The author has found the remedy to act best in the 12th and 30th potencies.—*The Clinique.*

O. S. Haines, M.D.

TREATMENT OF EPILEPSY.—C. G. Sprague, M.D., of Omaha, makes some statements in his paper upon the treatment of epileptics that are worthy the thoughtful consideration of every physician interested in the betterment of the condition of this unfortunate class. He says (and he draws his inferences from the history of a State institution established for the care of this class of beings): "It is a matter of record, taking these inmates from the routine treatment of the dominant school of medicine and prescribing according to the law of *similia* as nearly as we can interpret it, that the frequency of the epileptic seizures has been reduced during a period of eighteen months about 33 per cent., while the severity has been correspondingly relieved." Had this average been maintained for a few years, it is self-evident that a corresponding degree of improvement might have been continued. Prof. Ranney, in his work upon nervous diseases, makes the following remarks which ought to interest the homœopathic profession: "It should be remembered that a victim of chronic epilepsy who is rendered by *any* treatment as free from attacks, *without the use of bromides*, as he was when under their deleterious influence, has been *very markedly benefited*; and that, if a marked diminution of attacks has been effected, the patient has double cause for gratitude." Dr. Ranney would rather cure his cases of epilepsy by improving or curing an inherited constitutional dyscrasia, or by the removal of a reflex exciting cause, than by the use of the harmful bromides. Dr. Sprague treated his cases upon homœopathic principles, and among the remedies which he found useful, he particularly mentions *Artemesia vulgaris*, or wormwood. After referring to the

characteristic symptoms of this remedy, as shown by its pathogenesis, the author declares that this array of symptoms corresponds to the symptoms exhibited by a large number of patients, and, where the affection has not caused actual dementia, he regards it as the most valuable of all our remedies. Of course the remedy should be continued for a long time and in various potencies.

Dr. Sprague also used with success Cuprum, Silica, Indigo and *Ænantha crocata*.—*North American Journal of Homœopathy*. (The time may not be far distant when the homœopaths of Pennsylvania will have an opportunity of demonstrating the superiority of homœopathic therapeutics in the treatment of epilepsy and mental diseases.)

O. S. Haines, M.D.

BROMIDROSIS OF THE AXILLA.—C. D. Collins, M.D., reports in the Hospital Notes published in *The Clinique* the case of a girl aged 16 years who had been annoyed for the past two years by an excessive amount of sweating under her arms, which had become very offensive in odor. She was constipated; but, save for an acne vulgaris of face and forehead, enjoyed good health. The secretions only slightly colored the clothing, the special feature being its excessive quantity and very offensive odor. Examination of the parts revealed no local pathology. She was a brunette, and her skin was dark. Diagnosis, bromidrosis with hyperidrosis.

Treatment: *Lycopodium* 3x, with bathing of the parts in salt and water. The result was a cure within two months. In this case there was a dearth of symptoms, but the prescription was based on the well-known action of *Lycopodium* upon the glandular system and its regulating influence upon sebaceous gland secretions. *Lycopodium* is a remedy par excellence in offensive secretions, viscid and offensive perspiration.

O. S. Haines, M.D.

METHYLENE BLUE: SOME INDICATIONS POINTING TO ITS PROBABLE USEFULNESS IN BLADDER AFFECTIONS.—This remedy is one that has been recommended empirically for a variety of widely dissimilar conditions, and it really is time that some reliable indications for its use shall have been determined. Especially is this true, as the remedy has, on sundry occasions, produced symptoms which, to say the least, were most unpleasant. Encouraged by the roseate-hued reports of its wonderful efficacy, we have used it ourselves in a number of intractable cases; it being difficult sometimes to resist the temptation to dabble in experimental therapeutics and new remedies that are backed by the knowing as a sure thing, and being harder still to hold aloof and stick to the beaten paths if you have just a trifle of sporting blood in your veins which the grind of the strenuous medical life has not entirely eradicated. Methylene blue has never cured anything for us, so far. It has, however, upon several occasions, produced so much irritability about the vesical neck, and such severe tenesmus and dysuria, that we have been obliged to abandon its use. More than once these symptoms, combined with its remarkable color-effects, as evidenced to the patient and his family, in the urine and the vomited matters, have awakened suspicion that, after all, we were not the good old reliable family doctor, but only a specialist in masquerade. And so our conclusion has been reached that *our* patients cannot take Methylene blue until more definite indications for its use are known. Apropos of this experience, Dr. W. E. Reily, of Fulton, Mo., writing to

the *Medical Arena* for May, 1901, has something very interesting to say regarding the curative effects of Methylene blue in certain bladder affections; and this should be of interest to homœopathic physicians generally. The Doctor's attention was first directed to the remedy by its prompt action in a case suffering from intense tenesmus and dysuria. This patient was almost frantic, the remedies given had failed to relieve. Even Codeine in large doses had not ameliorated the sufferings of the patient. Methylene blue, however, in quite small doses, quickly cured the case. The most striking symptoms that have been produced by this drug are: Painful micturition, with violent and almost constant tenesmus. The urine is turbid, as a rule, with occasionally blood, mucus and pus in quantities. The pains are *burning* in character, and are *not* ameliorated by the frequent micturition. There may be incontinence, with considerable dribbling of urine. This remedy, says Dr. Reily, corresponds with every degree of inflammatory action, from simple congestion to pus formation. The symptoms are violent, and the pains markedly burning in character. Its principal action seems to be in the region of the vesical neck and in the urethra. Violent tenesmus with incontinence, the urine passing away drop by drop. It is an effective remedy, continues the writer, in cases of gonorrhœa, when the infection reaches the deeper urethra and the neck of the bladder. We may then use the lower trituration of Methylene blue with success.

O. S. Haines, M.D.

AORTIC REGURGITATION WITH MITRAL INSUFFICIENCY; FAILURE OF COMPENSATION AND DECIDED DILATATION.—The report of a clinic by Dr. H. V. Halbert in *The Clinique* for May 15, 1901, mentions a case of chronic cardiac disease (aortic regurgitation) in which, for the second time, there had occurred failure of compensation and decided dilatation. Upon examination, all the exaggerated signs of aortic insufficiency were found, together with the systolic murmur of mitral regurgitation. Hypertrophy had taken very good care of the left ventricle until an overexertion had caused a failure of compensation and decided dilation. Now, the resultant clinical phenomena pictured a clinical entirety with which every physician must be quite familiar: Dyspnœa, pulmonary congestion, extensive œdema extending to the thighs, albuminous urine decreased in amount, orthopnœa. The patient could only sit in his chair and pray for the end to come quickly. This, we say, is all very familiar, and, as Dr. Halbert remarks, it must be regarded as "an emergency" demanding prompt treatment. We are therefore interested in observing the *effects* of the emergency therapeutics of the author. His treatment was as follows: A light diet; teaspoonful doses of the infusion of *Digitalis* every third hour; *Apis mellifica* 3x., four tablets each hour. At times, when the respiratory distress increased alarmingly, hypodermics of one-sixtieth of Strychnine were administered. After several days' treatment, the patient presented signs of marked improvement, the urine gradually increased in amount, the dyspnœa abated, and finally compensation began to be again effectual. Halbert claims that by this "heroic treatment" we not only save life, but reach a stage where our indicated remedies may be used effectually, and with safety. He further states that he is satisfied that *Digitalis* is the drug which we should prescribe in these emergencies, as it holds the heart-muscle intact as no other agency will do. He would name the remedies to be considered in such a case about in the following order: *Digitalis*, Stro-

phanthus, Cratægus, (this acts better in the *beginning* of failing compensation), Convallaria, Strychnia and Sparteine sulphate.

Convallaria is indicated in the feeble action of the right heart, with pulmonary obstruction, also in very nervous patients. Sparteine refers more to the rhythmic disturbances with structural changes. In addition to this emergency treatment, we should not neglect the general conditions, such as anæmia, lung, stomach and kidney complications, which may afford indications useful in pointing out the remedy. (It is folly for anyone to criticize unfavorably this plan of treatment, mixed though it be; for it is quite impossible to determine *a priori*, how we shall manage such a serious condition as the failing compensation of chronic cardiac disease. Occasionally a single homœopathically indicated remedy (Lachesis, for example) will do all that could be asked. Sometimes the alternate use of two drugs (Digitalis and Apocyanum) will accomplish wonders. But in still other instances, we can perceive no response even to the most carefully selected similimums. We say there is no vital reaction, or that some mechanical obstacle (œdema) prevents the response. In such cases, we must perforce resort to physiologically or mechanically acting expedients, the therapeutic agent chosen being determined by the intelligence of the physician and the exigencies of the occasion.)

O. S. Haines, M.D.

MENORRHAGIA.—As Dr. E. S. Bailey remarked recently, a truthful report of a negative character has sometimes a very positive value. Therefore the statement made by Kate Graves, M.D., that in a case of obstinate menorrhagia she had used *unsuccessfully* Belladonna, Secale, China, Trillium, Hamamelis, Geranium and Ipecac, sets one thinking. But Dr. Graves in this particular case was very careful to tell us that there was no local trouble whatever, and that she had also put the patient to bed, and had tamponed. She had also used very hot douches, but just as soon as the patient began moving about, the hæmorrhage returned. The patient was forty-eight years of age, and her periods had been regular for some time. This patient was cured by taking three grains of the extract of *mammary gland*, four times daily; and since the cure menstruation has returned regularly, without the slightest tendency to hæmorrhage. Dr. Graves also mentions another case, of both menorrhagia and metrorrhagia, of five years' standing. The patient would not submit to curettage, although there was found to be uterine relaxation, metritis and endometritis. In this case also a cure was promoted by the same extract of mammary gland.—*The Clinique*.

O. S. Haines, M.D.

PUERPERAL CONVULSIONS.—Dr. P. C. Majumdar, the distinguished editor of the *Indian Homœopathic Review*, of Calcutta, India, describes an interesting case of puerperal convulsions which he cured by *Atropinum* 6, after Belladonna had apparently failed to do more than relieve the symptoms.

The patient, a thin, dark complexioned girl of fifteen years, gave birth to a male child April 19th. Mother and child did well for about a week, then lochia ceased and the patient complained of severe abdominal pains. The Doctor was called ten days after confinement and found patient with a temperature of 105° F., copious sweats without relief, scanty and foul-smelling discharge, intense headache and flushed face, pulse frequent and

irregular, bowels loose and yellow. She had at this time frequent convulsive fits of a violent character, unconscious during attack, rolling of eyes, gnashing of teeth, foaming at mouth, followed by deep coma.

He gave the patient Belladonna 30 and ordered milk and sago as diet. The next day the patient was in the same state, save that her temperature had fallen a degree, yet she seemed rather exhausted. He then administered *Atropinum* 6. Quickly the temperature fell to 101.5°, the convulsions diminished in frequency and the discharge lost its foulness. The rest of her symptoms improved likewise, and in one week she was well. (Nothing is said in this report about the use of cleansing nor antiseptic douches, so we presume none were given. While the omission of adjuvant treatment in such a case is always a hazardous proceeding, yet the action of the internal remedies in this case seem indubitable).

O. S. Haines, M.D.

TREATMENT OF PUERPERAL CONVULSIONS. — C. T. Hood, M.D., of Chicago, read a paper upon this subject at the May meeting of the Illinois Homœopathic Medical Society, which excited a very spirited discussion. After referring to the accepted opinion that the collection of symptoms which we call puerperal toxæmia is due to some toxin in the blood, the result of faulty elimination by kidneys, liver, bowels and skin, the author divided the treatment into first, preventive; second, medical treatment during the attack; third, surgical treatment. He thinks that when pregnant women have attacks of blindness or blinding headaches and are unable to sleep, they should have treatment looking towards the prevention of an accumulation of the special toxin in the blood. If the urine is scanty, he gives the following powder three times a day: *Apis* 1x. trit., 10 grains; *Citrate of Lithia*, 1 grain. Mix. With this he administers an abundance of soft, charged waters.

If albumin is present in the urine, he prescribes either Arsenicum, Mercurius cor., Mercurius dulc., or Veratrum alb., and allows buttermilk, cider and good spring water. In addition he recommends that the sluggish bowels of the pregnant woman shall receive prompt attention, and prefers to loosen them with *Senna*. He also gives the patient hot baths (100° to 105° F.) for from three to ten minutes. Such, then, is the preventive treatment recommended. His treatment of the actual attack of convulsions is about as follows: ten to fifteen minims of Norwood's tincture of *Veratrum Viride*, hypodermically, empty the colon, then fill it with normal salt solution. The salt solution might be given intravenously. Chloroform may be administered until other remedies have time to take effect. As soon as the patient can swallow, four grains of calomel with five grains of soda bicarbonate are given in capsule, to be repeated in two hours, followed in four hours by a saline cathartic. Should such measures fail, Chloral Hydrate in ten to twenty-grain doses by mouth or rectum should be administered.

This paper called forth quite a storm of disapproval from some of the members present. Dr. Bascom, for instance, protesting earnestly against the administration of four grains of calomel at one dose, yet at the same time approving of the *Veratrum vir.*, which he claimed was homœopathic to such conditions. Dr. Sawyer also protested against such therapeutic recommendations as unscientific and also unhomœopathic, and concluded by stating that his experience had convinced him that if homœopathic physicians would take the

time to study their cases, and would prescribe for them according to the homœopathic law, such cases need not occur. Dr. S. H. Aurand had found that Calomel did good in such cases where the system had been loaded with the toxin, and moreover it did its work quickly. He preferred it, therefore, to signing a death-certificate, even though, theoretically, it might not be the best remedy to use. A member present, whose name is not given, stated that he had found in his practice that the action of our remedies in the pregnant woman was one of the most wonderful things in medicine. Nevertheless, he admitted that in the one case of convulsions that he had seen he had resorted to Morphia to control the spasms, and that then the patient had recovered under *Veratrum vir.* Dr. Hood then closed the discussion, making a strong appeal from the point of view of the physician face to face with the case of such a woman, so convulsed that three strong men could hardly keep her from doing herself harm, and claimed that in such an emergency one could hardly select the curative similimum. (As Dr. Brickbauer, of St. Louis, said recently: "It follows, in accordance with the incontrovertible laws of nature, that different individuals, having different powers of observation, observing the same phenomena, will individually reach different conclusions, yet each will maintain that his observation is the correct one, because it corresponds with his individual experience.")—*The Medical Visitor*.

O. S. Haines, M.D.

FIRST EXPERIENCE WITH GOLD AS A REMEDY IN DISEASE.—W. Younan, M.B., C.M. (Edin.), being impressed with the remarks of the late Dr. Burnett regarding the curative effects of Gold, and especially the statement that it would induce a normal condition of health and virility if given to weakly, puny, sexually undeveloped boys, determined to try it in such a case then under his professional care. The lad, twelve years of age, was more like a girl in his disposition and physical condition. The mother of the lad declared that her son "was not made like other boys," whereupon Dr. Younan examined him, and found that neither testicle had descended, nor could he find any trace of them in the abdominal rings. He prescribed for the lad a one per cent. solution of *Chloride of Gold and Sodium*, and says he was able to observe a gradual improvement in the patient from this time on. His girlish voice and manner changed to those of a boy. He lost his shyness and began to be attracted by children of the opposite sex. Each testicle descended, and he became a well-developed lad. This was fifteen years ago. To-day the patient is a well-built man, married and happy, so the doctor says. Since that experience, Dr. Younan has often used this remedy, but he has found that it is just as effective when administered in the infinitesimal doses recommended by Hahnemann.—*Calcutta Journal of Medicine*.

O. S. Haines, M.D.

SULPHUR: INFREQUENT DOSES VERSUS RAPID REPETITION OF THE DOSE.—It has been a matter of observation with us during the past fifteen years, that the therapeutic effects of *Sulphur* may be augmented by administering it but once daily, and that dose about ten o'clock in the morning. This is not an original observation by any means. We probably learned it from some of our former teachers. There can be no doubt, however, as to its truth, as any one interested may confirm it by experiment. The frequent repetition of Sulphur in chronic ailments will not give us as good results in practice as will

the method above referred to, *i.e.*, one dose daily at about ten A.M. Try it, and see.

O. S. Haines, M.D.

WOUNDS OF THE EYEBALL.—Dr. Isaac C. Soule, of Kansas City, has an interesting paper upon this subject in the May number of the *Journal of Ophthalmology, Otology and Laryngology*, in which he naturally dwells at length upon the proper surgical treatment of such accidents. However, he refers to one case that should be of interest to the general practitioner, as it well illustrates the place of medicinal therapeutics in such serious emergencies. In November, 1899, a hunter was shot in the right eye. A stray No. 8 soft shot penetrated the upper lid and cornea and wounded the iris. The physician who was on the spot found no hæmorrhage in the eye nor escape of aqueous. Throughout the night (on the train) iced cloths were applied, changed every five minutes, and the patient received *aconite* and *arnica* alternately every half hour. The next morning Dr. Soule found the anterior chamber, which was intact, filled with a blood clot; there was hæmorrhage, preventing a view of the fundus, but a fair reflex was obtainable. A punctate wound was present, just internal to the nasal corneo-scleral junction, involving the iris close to its root. Vision, perception of light; tension, normal; no pain nor tenderness, except over site of wound. Conservative treatment was adopted after consultation; the eye cleansed carefully, a few drops of *scopolamin* instilled, the patient bandaged, put to bed, in a northwest room, from which all sun was excluded, and *arnica* continued alone. Treatment continued for *six weeks* as above described, when the *scopolamin* was discontinued for a few days and then used only once per day. Three months after the accident vision was $\frac{2}{20}$. Then *calc. sulph.* was given once a day, vision steadily gaining until, when discharged in August, 1900, the patient's vision with 0.50 D.c. ax. 90° was $\frac{2}{30}$.

(There is another moral to this tale, and that is: To achieve success we must be persistent. The persistency of the specialists in adhering closely to their chosen course of treatment is often remarkable. We general practitioners can learn something from the specialists about the use of remedies.)

O. S. Haines, M.D.

HYPERTROPHIED TONSILS.—When the tonsils are simply hypertrophied and not adherent, Dr. J. B. Garrison counsels the use of remedies carried out for a long time if necessary. He has at the present time a dozen or more cases of hypertrophied tonsils, mostly in young children, who have been taking remedies for from one to six months, and improvement is noted in all. The first thing noticed is that the sensation of a foreign body in the throat becomes less, and the tendency to take cold is decreased. A little later the tonsils commence to lessen in size. (If we can observe the gradual reduction in size, and can find the general health improving, we certainly can feel justified in continuing our medical treatment.) He says that so far he has found *bacillum 30*, or *higher*, the most useful remedy.—*Journal of Ophthalmology, Otology and Laryngology*, May.

O. S. Haines, M.D.

A NOTE ON IPECACUANHA AND THE VIOLACEÆ.—"It is stated that John Deer, the famous rattlesnake catcher, who died recently of old age, had been bitten scores of times, but always found a poultice of violet leaves an infalli-

ble remedy. We have not much faith in these supposed remedies for snake-bite, but this one is so curious and so well attested that it is at least worth scientific investigation. No doubt, as a rule, the people who employ these remedies upon themselves have really become immune to the virus through repeated slight injections, just as a man who has been stung several times by bees ceases to feel any pain. But, all the same, the subject is so important that John Deer's remedy should be considered."

This is interesting, for it is already known that *ipéc.* is very useful as an external remedy for the bites of insects, and now it appears that the *violet* has the same properties. The emetic principle of *ipécac.* is called emetine, and all the members of the *violaceæ* contain it, the roots especially being acrid and emetic.—Robert T. Cooper, M.D., in the *Homœopathic World*, June, 1901.

O. S. Haines, M.D.

FERRUM PHOS. AND CALCAREA PHOS. IN FRACTURES.—Dr. A. G. Lenders claims that the administration of these remedies in alternation, after the fracture has been properly treated surgically, facilitates union, relieves all pain, and ensures freedom from subsequent fever. He cites cases to prove the truth of this statement.—*Clinical Reporter*.

O. S. Haines, M.D.

VERATRUM VIRIDE.—Dr. Wilson A. Smith calls attention to the fact that this really splendid remedy has been much neglected by the profession during the past few years. There are several reasons for this. Doubtless much of the tincture of veratrum that is upon the office shelves of the doctors throughout the land is worthless, and would not act beneficially if it were prescribed. Again, it is a remedy that is at the present time a little out of fashion, a trifle *passé* in the opinions of those who are struggling to keep up with the "new things." Finally, it is a remedy not very often called for by the symptomatic picture, and really requires judgment and discrimination in its use, that good and not harm shall result from its administration. The author speaks of its specific action upon the respiratory tract, and thinks that often *Veratrum viride* presents, in its physiological action, the nearest simillimum to the first or congestive stage of pneumonia. It must not be persistently used unless its beneficial effects are promptly manifested, for it is only in the stage of congestion that it is indicated from a homœopathic standpoint. After fibrinous exudation takes place, it gives place to *Bryonia*, or some other remedy. The symptoms calling for the remedy are very similar to those present in the beginning of pneumonia: Full, strong pulse, flushed face, covered with cold sweat; difficult and labored breathing, convulsive breathing almost to suffocation, expectoration of pus and blood. The tongue frequently has a red streak down the centre.

Dr. Smith thinks that it stands above all other drugs for the cure of convulsions in children and in pregnant women. In the latter class of cases it slows the action of the heart, relieves the brain congestion, increases the flow of urine, and is one of our best remedies in puerperal convulsions. *Veratrum* has also won laurels in peritonitis. The late Prof. Ludlam paid it a high tribute when he said that if he could see the patient in time, that is, before exudation had taken place, he thought he could cure every case of puerperal peritonitis with this remedy alone. A tincture that is old is useless and inert. To get prompt effects, one must procure a fresh tincture of this drug.

O. S. Haines, M.D.

THE HAHNEMANNIAN MONTHLY.

AUGUST, 1901.

THE VALUE OF THE CARDIAC REFLEX IN THE DIAGNOSIS AND TREATMENT OF DILATATION.

BY CH. GATCHELL, M.D., CHICAGO.

(Presented to the American Institute of Homoeopathy, June, 1901.)

WHILE the superficial area of cardiac dulness can usually be readily demonstrated, it is not always possible by percussion over the area of deep dulness to obtain an accurate knowledge of the actual size of the heart. It often happens that two series of careful percussion outlines, made in the same person and within a short period of time, will vary in diameter from a millimeter to one-half centimeter.

The change in the area of cardiac dulness which often occurs during the process of percussion suggests the possibility that in response to cutaneous irritation applied over the precordium, a reflex contraction takes place which ultimately causes a marked decrease in the heart-volume.

It has been well known that a high degree of external friction over any organ which has a permanent or occasional approximation to the thoracic or abdominal parietes produces a reflex contraction of the underlying viscus. But it has only recently been demonstrated that the reflex contractility of the heart-muscle gives material aid to the diagnostician in differentiating between various forms of cardiac disease whose manifestations present a closely allied clinical picture.

In order to give a practical turn to the subject under con-

sideration, the cardiac reflex will be discussed only in reference to clearing up obscure and much-mooted diagnostic difficulties.

The above-mentioned ante-mortem variation in the size of the heart seems to be further confirmed by numerous autopsies, in which the apex of the organ failed to correspond to the position outlined during life. Within certain limits this is explained by post-mortem contraction and stoppage in systole; but the latter phenomena are not determining factors, except at the time of beginning dissolution and in cadaveric rigidity.

Properly to observe the cardiac reflex a good X-ray apparatus with a low-tension Crookes' tube is required.

For the cutaneous stimulation, any form of counter-irritation may be used.

Abrams, of San Francisco, first advocated the ether or rhigolene spray as being the most effective, but I have found that a brisk rubbing with a hand-brush of the ordinary soft rubber variety is equally effective. After the rubbing has been thoroughly administered for two or three minutes, the patient should be placed in front of the Crookes' tube, and the fluoroscope screen approximated to the chest-wall.

The noise of the static machine, together with occasional induction-shocks, may cause an undersirable increase in the respiratory rhythm; hence the patient should be constantly reassured that no harm can possibly result, endeavoring in this manner to secure a regular and quiet lung-expansion.

Abrams, in his original monograph, states that the reflex is more manifest on the left than on the right side of the heart; but after a close study of the skiascopic appearance I am not inclined to accept his view, in face of the fact that on expiration the ascent of the diaphragm at the pericardial attachment causes a confusing shadow, which undoubtedly at times gives the appearance of less activity in the lower right segment.

Curiously enough, a heart in massive dilatation gives a most exaggerated picture of diminution in size when reflexly stimulated. Marked precussional evidence can be obtained when the skiascopic picture shows the lessening cardiac volume; therefore, an area which was markedly dull before the reflex was induced now shows resonance. It is not to be inferred that the volume can be further reduced by increasing the stimula-

tion, for often a slight stimulus produces a greater contractility of the muscle than a manifestly prolonged and severe one. In this connection it might be well to state that the induction of a marked reflex in a dilated heart is in strong contrast to reflexes obtained in other hollow muscular organs, since in the latter activity becomes impaired just in proportion as the muscular constituents of the viscus become degenerated; and, as in the heart, we know that dilatation cannot exist a great length of time without degenerative changes taking place in the walls.

The prompt action of the cardiac reflex in dilatation of the heart led Abrams to regard the test as absolutely pathognomonic of this condition, and far exceeding all other methods of diagnosis in differentiating a dilatation from a pericardial effusion, since the reflex is said to be absent in the latter condition. This statement, however, will bear considerable modification, as the study of the mechanism of gradual effusion will show.

Obviously, when the effusion is profuse and sudden, percussional evidence of the reflex cannot be obtained. This is not due to absence of the myocardial recession, but to the quantity of fluid in the sac, which, together with the thickening of the layers, constitutes a physical condition which would give dullness, no matter how prompt the reflex might be. But the average case of pericarditis lacks the rapidity of process above mentioned. The friction-sounds present early in the disease are gradually obliterated by the increasing amount of fluid in the sac, and the reflex may be discharged during this period, and in doing so it gives percussional evidence externally.

Thus, it is reasonable to conclude that just in proportion as the fluid increases within the sac will the test be of value. It is a fact that more than half the cases of pericarditis have a small amount of fluid; rarely is there enough to cause interference and death. In the latter class of cases the test is admittedly pathognomonic; in the former class, which, to my mind, form the majority, the presence of the reflex does not by any means exclude pericarditis with moderate effusion. This is well shown in the following case:

Mr. H., age 54; physical examination showing all the signs of dilatation and valvular incompetence of the left heart. The condition was attributed to a chronic interstitial nephritis. The patient when first seen was in the recumbent position, with much

dyspnœa and facial cyanosis in evidence. A brisk friction over the precordium was followed in a short time by an appreciable diminution in the deep dulness. This reflex was obtainable at any time to within eight hours before death, although becoming less active toward the end.

On post-mortem, these conditions were all found as diagnosed; but, in addition, the surface of the heart was covered by a shaggy, fibrous layer; the parietal pericardium was rough and granular; the sac itself contained a considerable amount of a sero-sanguinolent fluid, due to co-existing pericarditis. The latter condition, however, did not in any way defer the bringing out of the reflex, nor was it during life suspected as a feature complicating the case.

The cardiac reflex was also obtainable in another case which afterward came to post-mortem: A male, aged 39, was seen three days before death. He was suffering from general miliary tuberculosis of the large serous cavities. The patient was extremely emaciated; respirations rapid and superficial; pulse irregular and intermittent, from cardiac arrhythmia. After the true dulness was carefully outlined, the precordial skin was briskly stimulated with the ether spray. After waiting two minutes—the time necessary for the lung to recede—a second careful percussional effort brought the dulness considerably within the lines which first indicated the limits of dulness.

At autopsy the oldest of the tuberculous processes was apparently that in the pericardium, as the cavity was partially obliterated by firm, fibrous adhesions, with numerous caseous masses along the line of union of the two layers. Yet, in spite of the limitation of motion the adhesion must have had on the myocardial recession, the heart reflex was present during life.

Thus the recession of the heart-muscle and diminution in volume of the chambers of the heart may be present in pericarditis obliterans, and in pericarditis with moderate effusion: and it is only pathognomonically absent when the effusion is so great in quantity as to cause death by interference with the heart's action.

The occurrence of the reflex under these pathological conditions of pericarditis and effusion and extreme dilatation of one or both ventricles only goes to show that the inhibitory centres of the heart are powerfully stimulated by cutaneous

irritation, whether by flagellation, cold water, or the electric brush. This profound action on the inhibitory mechanism of the heart is furthermore shown by the reduction in the heart-volume by the arrest of cardiac arrhythmia and lessening of the pulse-rate, as well as by evidences of nutritional improvement in the heart-muscle.

I am further convinced that the action on the heart-centres through cutaneous nerve-stimulation is greater and more profound in a therapeutic way than the result produced by the action of digitalis on the inhibitory centres of the heart. Digitalis, although it reduces the volume of the dilated heart, eventually produces a muscular weakness of the heart-wall. The muscular weakness is brought about as a result of the vigorous systolic contraction which the drug induces, without at the same time producing any favorable nutritional changes to compensate for the increased amount of work.

The Schott method of treatment has passed the experimental stage. Its efficacy has been established. It practically constitutes the only treatment in chronic dilatation that holds out any promise of success. But it is important to understand that its efficacy lies, not in the baths, nor in the resisted exercises, *per se*, but the essential element of the treatment to which the improvement of the patient's condition is due consists of the cardiac reflex induced by the cutaneous irritation excited by these manœuvres. This it does along strictly physiological lines.

In dilatation which has persisted for but a short time more or less myocarditis exists, and it is in this degeneration of the individual muscular fibres, and not in the valvular lesion, that the danger lies.

It is for this reason that the necessity exists for using measures which favorably influence nutritional metabolism in the heart-muscle before myocardial fibrosis becomes established. This can best be accomplished by the warm bath and friction of the skin—especially over the pericardium—by the hand-brush. This procedure, carried out for ten minutes each day with water at a temperature of 100 degrees Fahrenheit, will prove to be an efficient substitute for the Schott treatment, when for any reason the latter cannot be given in all its detail.

The fact that any therapeutic agent which does not induce repeated action of the cardiac reflex can have but a transient

beneficial effect confines the much-lauded digitalis to a very limited sphere. In this connection, moreover, I refer to the use, and not the abuse, of digitalis. Granted that the occasional exhibition of this drug in dilatation, where incompetence and arrhythmia predominate, results in some good, yet it is equally certain that digitalis, when administered long enough to become cumulative in action, actually lowers the plane of nutritional metabolism in the heart-wall. It can be safely said that if the exhibition of the drug, physiologically, for four consecutive days is not followed by the beneficial results desired, its further use is liable to injure the heart-muscle. The injury follows in spite of apparent improvement, consisting of more vigorous systolic contractions. Such contractions are toxic in their origin, the digitalis being the toxic agent.

In this brief paper I have attempted to establish the propositions that:

- (a) A cardiac reflex does exist;
- (b) The absence of the cardiac reflex in any given case is diagnostic of extreme pericardial effusion, and precludes dilatation;
- (c) The repeated induction of the cardiac reflex, in dilatation, is followed by an improved state of nutrition in the heart-muscle;
- (d) Digitalis, when administered long enough to become cumulative in its action, lowers the nutritional plane in the heart's metabolism.

PERSONAL OBSERVATIONS.*

BY JAMES C. WOOD, A.M., M.D., CLEVELAND, OHIO.

THE Medical Annuals, now accessible at small cost to all, make it somewhat superfluous for bureau chairmen to present to societies over which it may be their privilege and honor to preside summaries of the year's progress in medicine. This being the case, I have determined, in lieu of the usual résumé, to give a few personal observations for the purpose of clarify-

* Being the Presidential Address of the Second Annual Meeting of the Surgical and Gynæcological Association of the American Institute of Homœopathy, Richfield Springs, June, 1901.

ing certain points about which I am yet in doubt, as well as to emphasize certain other points concerning which there no longer remains any doubt in my own mind. I am afraid that some of us too often blindly follow leaders and teachers without asking the question, Why? Many times, theories based upon experimentation do not harmonize with clinical facts; the dicta of the laboratory, although seemingly conclusive, are not always to be relied upon. My object, then, is simply to give my own experience and conclusions, hoping thereby to excite helpful discussion of certain points which, a year ago, were considered finally settled. I shall also briefly refer to one or two somewhat unusual cases.

I shall consider, first of all, *postural drainage*. Muscatello, in 1895, demonstrated that beneath the peritoneal endothelium of the diaphragm, as well as between its connective-tissue fibres, there exist open spaces occurring in groups of 50 to 60, and which are from 4 to 6 micromillimeters in diameter. From the fact that these spaces are not found in any other portion of the peritoneum, and from the fact, also, that further experimentation showed that the lymph stream was in the direction of the diaphragm, Kelly was led to suggest the elevated posture as a prophylactic measure against post-operative peritonitis. This procedure was the final step in the evolution of the technique of peritoneal surgery during which it was shown by G. Wegner, Grawitz, Pawlowsky, Reichel, Waterhouse, and others, that the peritoneum under reasonably favorable conditions will care for pyogenic as well as non-pyogenic organisms. It was subsequently demonstrated by Kelly, Clark and Robb that the glass drain, so long in vogue, furnished an avenue for infection and resulted in infinitely more harm than good, which fact led most surgeons to substitute capillary drainage for the tube in most instances, when drainage was deemed necessary. The indications to-day for capillary drainage are largely limited to circumscribed abscesses shut off from the peritoneal cavity which cannot be reached through the vagina, or which cannot be enucleated, and extensive peritoneal infection. In intestinal and gall-bladder surgery a prophylactic drain may be called for.

In all other cases, as has been demonstrated repeatedly, the peritoneum will absorb not only large quantities of fluid (from

3 to 8 per cent. of the bodily weight in one hour), but, by the aid of leucocytes, solid matter as well. Muscatello first called attention to the importance of the leucocyte as a bearer of foreign particles from the peritoneal cavity. Solid sterile particles, such as portions of fecal matter, tissue débris, etc., may thus be either absorbed or encapsulated without the production of peritonitis. Further experimentation proved that the power of the peritoneum to care for infectious material of all kinds, as well as fluids, was greatly increased by elevating the body to such a degree as to bring gravity into action in promoting the lymph-flow toward the diaphragm. Another object in elevating the foot of the bed was to prevent the stagnation of fluid in the pelvic dead spaces.

Theoretically, then, there is much to be gained by postural drainage. There is, however, one factor to contend with which I have not yet seen in print, and which I believe to be of the greatest importance. For almost countless ages man has been an upright animal. To place him in bed, after temporarily paralyzing his abdominal functions by the degree of peritoneal trauma which follows an ordinary celiotomy, in a posture which reverses intestinal peristalsis, and which causes the intestines to gravitate towards the diaphragm, is, in my opinion, to court adhesions and obstruction. Time will not permit of extended discussion of the many predisposing causes of ileus and intestinal paralysis, as well as of peritonitis. Were such a discussion permissible, it would involve many questions pertaining to surgical technique and antisepsis. I shall aim rather to give, as I have said, my personal experience with the various conditions touched upon, which, in the condition under consideration, is decidedly opposed to postural drainage. In a series of 100 celiotomies in which it was practiced I had infinitely more trouble to get the bowel opened than I ever had before, or have had since. Besides, tympany was much more marked, while nearly all patients complained of the distress incident to the unnatural posture. I lost one case from ileus, reported at the last session of this Society, which was one of the simplest cases of appendicectomy and oöphorectomy I ever did.

One needs but look into the pelvis from above while the patient is in the exaggerated Trendelenburg posture to see how futile is the endeavor to empty the pelvic dead spaces by ele-

vating the foot of the bed 18 inches or 2 feet. I instruct the nurse to turn the patient upon her side at least four or five times during the first twenty-four hours, and encourage her to lie in this position for some time. This will empty the lower dead spaces better than it is possible to empty them by any degree of elevation which the patient can tolerate.

While, then, the arguments based upon experimentation go to show that postural drainage facilitates the absorption of fluids left or poured into the peritoneal cavity, my own observation leads me to believe that its advantages are more than offset by the reversal of peristalsis which it excites.

Undoubtedly many lives have been saved by substituting saline cathartics for morphine in the treatment of peritonitis and the post-operative treatment of celiotomies, a practice inaugurated by Lawson Tait. In tympany, with vomiting and increasing temperature, there is nothing in abdominal surgery more satisfactory than the relief which usually follows free catharsis obtained either by purgatives or enemata. All, or nearly all, of the modern text-books dealing with peritonitis, ileus and vomiting (sepsis being the cause oftener than anything else), recommend persistent and continuous effort to obtain free catharsis. I believe that this treatment can be overdone. Given a case of celiotomy 24 hours old, with a rise in temperature of, say, from 1 to 2 degrees Fahrenheit, and with more or less prominence of the substernal region, the indications are clearly to empty the bowel. My method of accomplishing this, which I believe is the one generally followed, is to give $\frac{1}{10}$ of a grain of calomel every half hour until a grain is taken, which is to be followed by a Seidlitz powder divided into three portions, and given at intervals of ten minutes. This is repeated in three hours, if necessary. At the end of three hours, if this does not open the bowel, a high cathartic enema is used composed of magnesium sulphate, glycerine and water, each 2 ounces, to which is added, if the tympany is very marked, from 1 to 2 drachms of oil of terebinth. Should this fail to start either flatus or fecal matter, another effort may be made from below,—glycerine, oxgall or oil being substituted for the cathartic enema. If failure again follows, most authorities advise persistent effort until a successful evacuation is obtained. In the event of much prostration, I believe it a mistake to perse-

vere too long, after one or more failures by the measures given. The administration of high enemata (and in these cases nothing but high enemata are of the slightest avail) creates a dangerous degree of shock in a patient already exhausted, and adds to the bowel paresis invariably present. I believe that I have saved the life of more than one patient by desisting from further effort, if the conditions described prevailed, for from 12 to 24 hours, giving in the meantime hypodermatics of strychnia, and, if the restlessness is very marked, a quieting dose of morphia. Not infrequently, after a few hours' rest, the paralyzed bowel regains its tone, flatus begins to pass per anum, and a free watery evacuation takes place. Should this fortunate termination not occur, we can more safely resume our efforts after the patient has had eight or ten hours' rest. While I think that the bowels should be freely emptied previously to all surgical work, I fully agree with Dr. George W. Roberts that purgation can be overdone in pre- as well as in post-operative work, and that there is at all times danger of producing tympanites and bowel paresis by the too free administration of cathartics.

For the last ten years I have made it a rule, after each operation done by me, to dictate the exact technique to a stenographer, as well as the history of the case, if not previously obtained, the nature of the work done, etc. Whenever it has been possible I have endeavored to learn the subsequent histories of my patients, so that I have accumulated data which, to me at least, is instructive. In each instance I have recorded the method of closing the abdominal wound, and find, upon reviewing my records, that I have employed nearly all methods in vogue during the last 20 years. Until 7 years ago I used almost altogether the through and through silk sutures, and, while stich-boil abscesses were not uncommon, there were comparatively few parietal abscesses of any great size. I then experimented with the buried animal, silk and silver-wire ligatures with varying degrees of success. Increasing experience has led me to discard entirely all non-absorbable buried sutures in the abdominal wound. Possibly my aseptic technique was at fault, but every now and then a buried suture gave me trouble. During the last two months I have removed wire sutures from two cases, operated upon by a most skilful surgeon, which worked their way to the skin-surface. If catgut could

be absolutely depended upon, as regards both sterility and durability, the ideal method of closing the abdominal wound would be to close it by careful approximation with successive layers of catgut. While we are reasonably certain of the antiseptic qualities of catgut if prepared under the eye of the surgeon, we cannot, unfortunately, always be so certain of its durability. I believe that ventral herniæ not infrequently result from the too early absorption of catgut or its giving way under the tension of excessive emesis. During the last year I had two abdominal wounds open up in which I relied upon a new preparation of catgut, without anything more than broad strips of adhesive straps and the usual abdominal binder to reinforce it.

In 52 recent celiotomies I adopted the following technique, which has been eminently satisfactory: The peritoneum is first closed in the usual way with a running catgut suture. Silkworm-gut sutures are next passed, by means of a fine curved needle, three-fourths of an inch apart and one-half inch from the wound edge, through skin, fasciæ and muscle, and out through the corresponding side in reverse order. After these are passed and secured in forceps, the fascial covering of the recti is carefully approximated with a second running catgut suture. The skin is then closed with a subcuticular silkworm-gut suture, after which a folded strip of gauze wrung from a 1-2000 bichloride solution is placed over the wound and held in place by tying over it the silkworm-gut tension sutures, which are secured just tightly enough to close the dead cellular space underneath the skin. The tension sutures are removed at the end of a week or ten days, and the subcuticular skin suture at the end of two weeks. If fine needles are used for the tension sutures, the resulting scar will be almost imperceptible. By their use not only are all dead spaces overcome, but the wound is so securely closed that there is not the slightest danger of injuring from straining during emesis. *No matter by what method a wound is closed, suppuration will be of frequent occurrence if dead spaces are not overcome.* I have observed, too, that when through and through sutures of whatever material are used, and tied sufficiently tight to approximate the edges of the wound, the evidences of strangulation are to be seen in from two to six days following the operation. By tying the sutures

over a sterile gauze compress this is largely overcome, the wound at the same time being practically sealed by the compress. In the 52 cases in which this method was followed I have had to do with wound infection in four instances, three of the four cases being septic to start with.

I have had some unpleasant experiences in the use of iodoform and bichloride of mercury which I desire to call the attention of the profession to. Five years ago, Dr. Malcolm McLean described the toxic effects of iodoform as follows:

Cutaneous Irritation.—Eruptions of the skin in erythematous or eczematous form, associated with the pruritus of urticaria.

Cerebral Disturbances.—Headache often very marked; delirium more or less active; melancholia and hallucinations; the pupils occasionally dilated, but more often contracted and motionless; the pulse decidedly accelerated, running early up to 136 or 150 per minute; quality rather small and wiry; rapid increase of temperature.

Syncopal or Asthenic Form of Poisoning.—Patient overcome with dizziness; mental confusion; great lethargy; weak, rapid pulse; some paralysis of the sphincters, death coming sometimes suddenly by heart failure.

Berkley, in his recent work on mental diseases, also refers to iodoform poisoning as a cause of insanity. In a case passing under my observation hallucinations followed the introduction of an iodoformized drain, which was left behind after an appendicectomy. On the third day of the convalescence there was irritability and disquiet, and very soon the patient did not recognize her surroundings. It was extremely difficult to keep her in bed. The temperature ranged from 99° to 101° F., and the pulse from 110 to 120. There was slight albuminuria, and the urine showed the characteristic iodine reaction. These symptoms persisted for six days, and only disappeared after the gauze packing was removed and the external iodoform dressings were abandoned.

Several additional cases of iodoform poisoning have come to my notice, so that I have practically abandoned the agent as a surgical dressing in any form, and, I believe, much to my patients' advantage, as well as to their comfort. It is true that in the majority of instances a reasonable amount of the drug can be used with apparent impunity, but I know of no way of

determining, previously to operating, the peculiar idiosyncrasy which places the patient in danger by its use. When it is necessary to leave behind, in any of the cavities of the body, gauze for the purpose of drainage or creating pressure, as in an appendicectomy or uterine hæmorrhage, an iodoformized preparation will remain sweeter much longer than any other; but "washed" gauze should be used instead of the strong 10-per-cent. formulæ. I believe that a good many patients have been killed by the indiscriminate use of iodoform within the peritoneal cavity.

Again, are we not using bichloride of mercury too indiscriminately in our surgical practice? One need but refer to the pathogenesis of this drug to see how dangerous an agent it becomes when toxic doses are given. It causes tenesmus of the bladder with suppression of urine; the urine becomes scant, hot, bloody, albuminous, and is passed in drops with great pain. These symptoms are but a few of the many which follow in the train of mercuric poisoning, but are sufficient to warn the surgeon that this most powerful agent for good may become terribly destructive unless used with care. In nearly all the methods in vogue for preparing the abdomen previously to celiotomies, a bichloride compress varying in strength from 1-500 to 1-2000 is recommended. After the skin-surface has been washed and scrubbed in the usual way before the compress is applied it becomes very absorbable, and I believe will many times permit sufficient of the drug to enter the system to unfavorably affect the kidneys. At least, while using it I had frequently to contend with renal insufficiency and uræmic manifestations, even though previous examination of the urine suggested no kidney lesion. Since discarding the bichloride compress, substituting for it sterile gauze, the complications mentioned have become much more infrequent. It can be used, I think, as strong as 1-1000 with comparative impunity in scrubbing the skin-surface when it is to be immediately washed off, but it cannot, in my opinion, safely be used in the strength of 1-2000 when applied in the form of a compress.

Since the last meeting of this Society I have operated upon 26 additional cases where I found appendicitis associated with disease of the female pelvic organs. Increasing experience only confirms in my mind the importance of this subject, which

I especially emphasized in a paper ("Appendicitis Associated with Diseased Conditions of the Female Pelvic Organs") presented to you one year ago. The changes found in the appendix varied from mere catarrhal inflammation, with slight interstitial infiltration, to extensive thickening or cystic distention. In none of the 26 cases did I find foreign bodies other than coproliths, which is additional evidence that the morbid fear which afflicts the laity regarding the ingestion of seeds is largely groundless. The point that has impressed me more than anything else in connection with this subject is the disparity which many times exists between the appendicular lesion and the symptoms produced. Eleven of the 26 cases were acute, and in 5 of the 11 there was found simple catarrhal appendicitis associated with a moderate degree of inflammation of the right uterine adnexa, notwithstanding that the symptoms were of the most violent character. In 2 of the 5 cases I felt sure, previously to opening the abdomen, that perforation had occurred, there being persistent nausea, extensive tympany, rapid pulse, and the usual indications of collapse. Recovery in both instances followed immediately upon appendicectomy and the correction of the ovarian lesion.

The deductions to be made from this experience are, clearly, that we cannot rely upon the constitutional symptoms in determining the necessity of operative interference. Fourteen of the 26 cases had had one or more previous attacks. In all of the subacute and chronic cases there were intestinal indigestion with flatulence, constipation (in three there was alternate constipation and diarrhœa) with mucous stools, foul tongue, bad odor to the breath, and frequent gastric headaches. In 6 of the 14 cases there was a movable kidney, which was corrected either at the primary operation or subsequently. In 5 of the 6 kidney cases there was a degree of enteroptosis which will necessitate the wearing of an abdominal support for years to come. Two of the acute cases were fatal—one death resulting from uræmia, the patient having had for some years chronic Bright's disease; the second death was due to sepsis, there being a large abscess, including the appendix, which had not attached itself to the abdominal wall in front.

One experience with nephropexy is of more than passing interest because of the proposition recently put forth by Edebohl

(*Medical Record*, May 4, 1901; *Medical News*, 1899) that the operation is beneficial in chronic nephritis, and that surgical intervention is justifiable in this disease even though the kidney is not mobile. Edebohl makes the somewhat startling statement that "in 18 nephropexies performed upon patients with chronic nephritis, the interesting observation was made that a cure of the nephritis followed operative fixation of the kidney in a large proportion of cases. Albumin and casts disappeared permanently from the urine." Basing his deductions upon this experience, Edebohl proposes in chronic nephritis, either in movable or normally located kidneys, to denude the kidney of its capsule proper for the purpose of creating a new vascular connection between the blood-vessels of the kidney and those of its fatty capsule. He believes that the collateral circulation thus established will relieve the chronically inflamed kidney.

In September, 1900, I operated upon Miss C., æt. 22, for a movable right kidney which, when in the upright posture, found its way into the pelvis. The patient, who was a dentist's assistant, had to be much on her feet, and the displaced organ caused a degree of suffering which practically incapacitated her for work. On September 24, 1900, I fixed the kidney through the usual lumbar incision by means of four chromicized gut sutures passed through muscle and fascia. It seemed but little enlarged, and, so far as could be determined by palpation and sight, was perfectly normal. The urine gave no evidence of interstitial inflammation. Convalescence from this operation was continuous and complete.

The patient returned to her home in the interior of the State, and was almost entirely free from pain for two months. At the end of that time the aching and dragging sensations recurred, and her physician, upon examination, found the kidney again loose, though not as low in the abdomen as before the fixation. She returned to me in January of this year thoroughly discouraged, being entirely dependent upon her own efforts for support, and requested me to remove the troublesome organ. I found the kidney considerably enlarged, and, as I had taken every precaution in the first operation to secure its fixation, I decided to comply with her request. On January 25th I made an abdominal nephrectomy, and much to my sur-

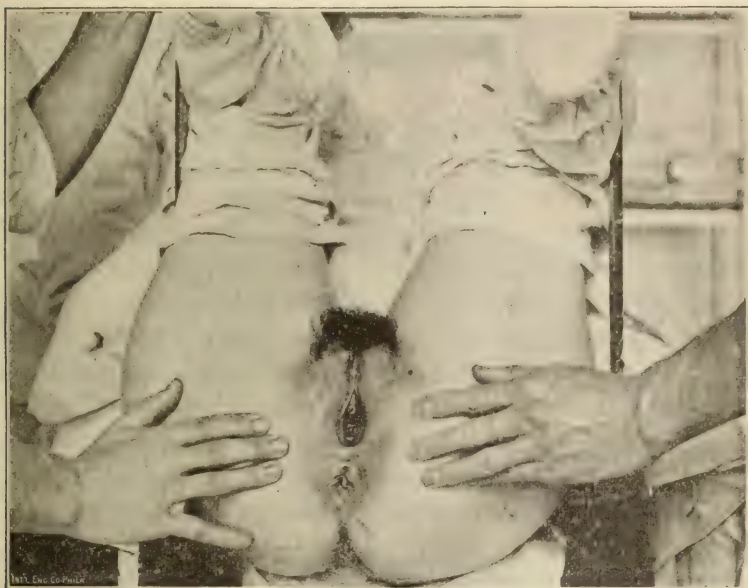
prise found the entire convex portion of the kidney intimately adherent to the lumbar fascia, the adhesions being so firm as to require not a little effort to overcome them. The mobility was due to the separation of the lumbar fascia from its underlying muscle, with stretching of the same. The adhesions were practically non-vascular, and therefore could have supplied but little "collateral circulation." The kidney itself was enlarged to twice its former size, and on section the entire cortical area corresponding to the field of fascial attachment was infiltrated, the hardening extending well down into several of the columns of Bertini.

I would not for a moment permit myself to make final deductions from one case of this kind. Doubtless, had the kidney remained fixed, much of the infiltration would have disappeared. The opportunity to examine the kidney four months subsequent to its fixation does not come to many surgeons, and renders it possible to study the changes incident to the operation. The conviction forces itself upon one that the changes noted would hardly be beneficial in a nephritis already present. It suggests, also, the probability that Edebohl reasoned from false premises; that the nephritis in the cases operated upon by him was due to congestion and ureteral obstruction incident to the displacement; and that improvement followed, not because of the collateral circulation established, but rather because the factors cited as provocative of the congestion and obstruction were overcome.

Kraurosis vulvæ is so rarely met with that I take this occasion briefly to report a case, a photograph of which I show you. I removed the patient's ovaries six years ago, which were cirrhotic. She is now 32 years of age, and, I believe, a virgin. She got up from the celiotomy in good shape, and remained well until nine months ago. Then there began an intense pruritus of the vulva with intolerable burning. The condition persisted until she presented herself to me during March of this year. Upon examination I found the affected area red and exquisitely sensitive, with discolored spots here and there. The mucous membrane had so contracted as to cause coarctation of the ostium vaginæ, with decided gaping of the orifice. Above the coarctation the degree of contraction was such as to make it difficult to insert the finger into the vagina. The stenosis was

more apparent than real, and in a large measure was due to spasm from nervous apprehension. These distressing symptoms were entirely relieved by a free dissection of the diseased area and uniting by interrupted sutures the healthy mucous membrane from above to the skin-surface.

This is the first case of kraurosis vulvæ passing under my observation. Breisky first directed attention to the subject, reporting 12 cases. Fleischman found 8 cases in 1550 patients. Lewin failed to find a single instance of it in 70,000 patients examined at the Charité. Tait applied to the disease the term



Case of Kraurosis Vulvæ.

“Progressive Atrophy of the Nymphæ.” The etiology is uncertain. For a time it was supposed to be due to syphilis, but this theory has been disproved by Lewin and others. It has been met with oftener at or after the menopause, or after oöphorectomy. Not infrequently the disease is associated with, or preceded by, a vaginal discharge.

Microscopically the red spots are made up of dilated capillaries and nerve-fibres. The epithelium is of very irregular thickness, and contains, in places, small rents or fissures.

Palliative treatment is of little avail, though such applications as phenol, a solution of neutral acetate of lead in glycerol,

and the stick-silver nitrate, may afford temporary relief. The curative treatment is purely surgical, and consists of removing an ellipse of mucosa from either side of the introitus, the margins being united by interrupted sutures. This has afforded relief in all cases reported.

In conclusion, I want to again emphasize the value of compressed air and the spray in the local treatment of gynecological diseases. Time will permit me to do little more than call attention to a recent article by me on the subject published in the *American Journal of Obstetrics and Diseases of Women and Children*, vol. xliii., No. 3, 1901. I now consider the spray invaluable in dealing with chronic cervical endometritis, vaginitis, urethritis, urethral carunculæ, inflammation of Skene's glands, chronic proctitis and sigmoiditis, and the various eczematous diseases of the vulvar and anal regions. I recognize the fact that many of the lesions enumerated are due to causes which require for their correction mechanical measures. I also recognize the fact that many of the catarrhal affections will often continue indefinitely under the older régime, even though the primary cause is removed. One needs but to study the glandular character of the tissues involved in catarrhal diseases of the mucous membranes to appreciate the advantages of forcing medicaments into them by means of a spray of high pressure, over the usual tamponing and swabbing process. To me, the wonder is that the spray did not long ago come into general use in the local treatment of the diseases of women. For the technique of its application, as well as for a discussion of the medicaments which I have found most serviceable, I shall have to direct you to the article referred to.

SOME NOTES ON THE BACTERIOLOGY OF ACUTE ARTICULAR RHEUMATISM.

—Dr. Singer, of Vienna, from bacteriological examination of five cases of acute articular rheumatism and two of rheumatic chorea which ended in death, found the articular exudate to be sterile in all these, though in the periarticular tissues, the tonsils, and in the endocarditic vegetations, the streptococcus pyogenes was detected in a pure culture; in one of the cases of chorea the staphylococcus aureus was found. The streptococcus was demonstrated to be of the ordinary pyogenic variety. Therefore, articular rheumatism is to be looked upon as an attenuated form of pyæmia. We have no reason to think that a certain specific streptococcus is the infecting agent in this disease.—*La Semaine Médicale*, No. 19, 1901.

THE MEDICAL TREATMENT OF APPENDICITIS.*

BY J. ARTHUR BULLARD, M.D., WILKES-BARRE, PA.

ONE of the first essentials of the physician who is called upon to treat this diseased condition is to see things as they are.

First, to recognize that "Man is not an organism, but an intelligence served by organs."

That the appendix is an organ, and has its use in the economy of Nature; to remove it without cause is to mar and cripple God's noblest work.

Second. The physician must divest himself of the idea that appendicitis is a surgical disease, for the results of treatment prove that it is not; and, as I shall show you by the cases reported later, it is very exceptional when the case that is treated homœopathically has need of a surgical operation for its cure.

The appendix was not, as many seem to think, simply thrown into the abdomen as a coupon—to be cut off by the first impecunious surgeon turned loose in its neighborhood.

Now, we have all been told many times, and told more beautifully, more scientifically, more logically and more strenuously than I could ever tell, why we *should* use the knife in these cases, or, better still, turn them over to the man who makes the money—the surgeon! the expert! the fellow who does nothing from rise to set of sun but abdominal sections, until he is that slick and skillful that he can do them backwards, forwards, or skipping, with his eyes shut, his hands behind him, or perhaps while standing on his head—who counts his flaps and sections by means of algebraic equations, while the sterilized catgut and other ligatures he has used since he got in motion—"gut to gut," so to speak—would string a rainbow.

Now, right here, lest I forget, I wish to go on record as saying that if you ever should, in a long, busy life, and after curing a few hundred cases of appendicitis, get a case too late for

* Read before the Inter-State Homœopathic Association at Binghamton, N. Y., May 23, 1901, and published in the *HAHNEMANNIAN MONTHLY* by special resolution of the Society.

your remedies.—one that really demands operation,—the man who does nothing but surgery is the man by all means to do the trick. Don't attempt it yourself without you are obliged to, but if you are so caught, do your best, and don't forget the saving grace of the indicated remedy; never be afraid to do all in your power, for sometimes to be too conservative is to be almost criminal.

Then, the third requisite demanded is common sense, and as good a knowledge of homœopathy as you are capable of absorbing. If wanting in the former, you need a lot of the latter; while, if you are filled to the brim with the first-named, you can slip through very creditably with less *materia medica* than otherwise, while if your common sense, judgment and *materia medica* are all shy in a round-up, the knife is naturally your trump card.

The number of cases of appendicular disease a surgeon who knows not his *materia medica*, a surgeon who loves his scalpel, and who possesses the instincts of a hunter, can find in a thinly-settled ward is almost phenomenal. He reminds one of the little boy turned loose in the woods for the first time—every rabbit is a bear, and every bear a buffalo; for, to this searcher for visceral trouble, every stomach-ache is at least suspicious, and a sensitive ovary or fœcal impaction in the same voting-precinct as McBurney's point gives cause for surgical rejoicing, and at once the leaven of mistrust and apprehension works most mightily in the minds of the patient and family, until in a twinkling the day is set, the nurse engaged, and ye gallant surgeon saves another sweet life from the grave that yawned so desperately near. "Thank heaven, my dear sir, that I was called in time; another twenty-nine minutes, and you would have lost your darling child!"

And such is life and surgery in large cities, where much money accumulates.

Ah! what would they do, were it not for that "point" that made one Mr. McBurney famous? And what would we as a profession do, were it not for that many-stringed harp, the nervous system, and the ladies?—"God bless them!"

Another thing to bear in mind in the *medical* treatment of appendicitis is this: The appendix is left where the Creator placed it. The owner and sole proprietor of said worm is sound

and well, and will stand an inventory. The fees, if any, are in the medical man's pocket, and the "cut first and question later" surgeon is whistling through his fingers or on another rabbit hunt.

During the past three years I will not hesitate to say that at least fifty cases of so-called appendicitis, many of which were distinctly hysterical in character, have been operated in the city of Wilkes-Barre alone, and for a time it became as much of a fad or fashion as the size of a lady's sleeve. In fact, to be really a lion in the social swim, so to speak, or to be amusingly interesting, you must part with this little friend of the latter-day surgeon. During the scare period mentioned as many again cases, real and spurious, were cured by the homœopathic remedies, and very many of the cases diagnosed by the patients themselves were promptly relieved by one or two prescriptions of *ignatia* and a few reassuring remarks.

Now, what should be more convincing than plain, straight facts?—facts, with still harder facts behind them. Yet how difficult it is to interest, or to attempt to interest, any one with just cold facts, and so medical writers and other novelists use words, torrents and avalanches of words; and I only wish I could command them. Why, I feel so strongly that I am right on this subject that I would give much had I the power to embellish and trim and adorn these appendicular facts with a whole dictionary of nice, fat, rich, juicy words. Still I must say that I have sometimes noticed, when listening to papers on medical and other subjects, not by little red-schoolhouse men like myself, but by real able fellows who know just how their hair should be parted to look its best, they all have such good command of words that sometimes, when they attempt to explain why one should do this, or why you should not do the other thing, they use so many words that, like the cuttle-fish, they frequently hide themselves and their subject, for the most part, in their own ink. Still, from now on I want to avoid this, and will try to be brief; for some one has said, "If we would be pungent, be brief, for it is with words as with sunlight—the more they are condensed the deeper they burn." So now for the condenser.

When, last November, at the meeting of this Society, held in Scranton, I heard Dr. Roberts' scholarly paper, entitled

"Appendicitis: Choice of Method of Treatment," I was impressed by the smoothness of its rhetoric and fascinated with its entire command of the subject; but later, when I read it carefully in THE HAHNEMANNIAN, and discovered there was *no choice*, that there was absolutely but *one* method, the title to Dr. Roberts' paper seemed a misnomer; it should have been called "The Surgical Treatment of Appendicitis."

Why, it didn't even leave a rudimentary leg for any other treatment to stand on; it placed expectancy and medicine on a par with each other, and intimated in a polite and courteous way that they are neither of them worth consideration, and that there are but two safe places for an appendix—one at the end of a book, and the other in a surgeon's vest pocket.

For a moment or so I was startled. "Is it likely—is it possible"—said I to myself, "that I am *It*, the *only* physician who cures this disease with remedies? Don't I know a case of appendicitis when I get one? Didn't I have a rattling attack myself five years ago? Haven't I been called professionally to treat these cases in all states and stages? Is it possible that the cases I have been calling appendicitis, and curing as such for the past fifteen years, have been housemaid's knee or spring fever?"

Well, when I was appointed to prepare a paper for this meeting, what did I do? I went back to the books of record and hunted up my cases, some with copious notes, others more meagre, but positive and more convincing, and scores of living witnesses.

So far, so good. But I was lonely, so I wrote a few letters of inquiry to some men I knew; men who have stood the test of time—two being classmates of mine at old Hahnemann.

My other correspondents, while younger, were also men able to diagnose a diseased appendix, able to treat it with medicine, honest enough to call a surgeon if needed, and truthful and conservative in their statements.

I have had answers from all but one, and I am going to give you the results, starting with my own.

Since the profession have been able to diagnose diseases of the appendix with reasonable accuracy, I find I have treated more than one hundred cases; and as this list excludes nearly twice that number of doubtful, obscure and hysterical cases,

many of which were good counterfeits, I feel that I can justly claim one hundred cases of the real thing during the past fifteen years, while for the fourteen years before that I can recall a number of cases that I am now satisfied were cases of appendicitis, although treated for inflammation of the bowels or some other abdominal viscera not specified. Dr. E. E. Snyder, of Binghamton, makes an equally conservative statement of seventy-five cases. Dr. R. Murdock, of Wilkes-Barre, with equal care reports fifty cases. Dr. H. D. Baldwin, of Elyria, Ohio, whom I have long known to be a careful, conscientious observer, sends me a list of ten cases during the past three years.

Dr. L. D. Tebo, of Bordentown, N. J., reports in detail two exceptionally severe cases. Dr. D. S. Kistler, of Wilkes-Barre, reports twenty cases during the three-year limit. Drs. Johnson and Hill, of Pittston, together with Drs. Coe and Brooke, of Wilkes-Barre, report sixteen cases, the accurate diagnosis of which they are willing to vouch for. Dr. J. H. Sandel, of Plymouth, sends me twelve cases. And, having now two hundred and eighty-five cases reported, let us see what some of the doctors say:

Dr. Snyder says: "I have never had a case operated, and have never lost a case."

Dr. Murdock says: "I have never had a case where I thought surgical interference necessary, and have taken all my cases through to perfect health."

Dr. Baldwin says: "These cases will all bear investigation, and are alive to tell their own story. Believing that many hundreds of cases are treated and cured without the knife, I remain," etc.

Dr. D. S. Kistler says of his twenty cases: "Eighteen of them recovered without surgical aid, and seem to have completely recovered. Two of the twenty I sent to the hospital for operation, and both died."

Dr. Hill states: "All were successfully treated with homœopathic remedies, and there has been no recurrence in any case."

Dr. Johnson: "Have never lost a case, have never had one operated."

Dr. Brooke says: "I am firmly convinced that there is need for operation in but a very small percentage of cases."

Here, then, we have a total of two hundred and thirty cases reported, two hundred and twenty-eight of which were treated by acon., bell., bry., dioscorea, ars., rhus., echinacea, veratrum, colocynth, cham., lach., mercurius, hepar, mag. phos., these being the remedies mentioned by those making the reports.

Adjuvants, olive oil per mouth and rectum, hot salt enemas, high injections, oil poultices, fluid foods, hot water taken frequently per mouth.

Now, what rather surprised me was the small list of remedies mentioned, and the fact that these two hundred and twenty-eight patients were treated and cured with but fourteen remedies, and the single remedy being all that was required in many of them.

I take it for granted that we are all familiar with the symptoms of the disease in question,—how in many instances there will be a persistent abdominal pain for months, varying in degree, never quite severe enough to drive a busy man to the doctor, but at times quite enough so to make him think about it. Almost absent at times, more severe at others, until finally a much more acute attack leads to a consultation and the discovery that we have a case of chronic catarrhal appendicitis to prescribe for.

Then there are the other varieties, where no previous history can be elicited, and the patient is suddenly seized with pains and symptoms too positive to be misunderstood, and we have an acute attack for our consideration.

Now, to successfully treat appendicitis with homœopathic remedies the physician must necessarily be a homœopath; and while many are masquerading under the name, for commercial or selfish reasons, the real article is fast dying out, and the species bids fair to be soon classed with the Dodo and Great Auk.

To the physician who is willing to prescribe for his cases of appendicitis, as did the men who founded the homœopathic school, to the doctor who will carefully individualize each case and give the indicated remedy, success is sure; and while fame and fortune come slow to such quiet workers, and the great world passes them by as mere plodders, they are, notwithstanding all this, the strength and safety of their patients, standing, as they thus do, between them and the great bodily harm of needless surgery.

Now if Dr. Snyder and the other doctors quoted can cure 100 per cent. of their cases of appendicitis, and if I, with my poor, crude knowledge of this homœopathic art, can truthfully say that I have treated one hundred cases without a death, without even the flash of the knife, and without even one case leaving me to go to a surgeon—why, in the name of the Great Healer, should this disease be pronounced a surgical proposition?

And why should so many worthy men try to hammer into our heads and the heads of the medical students that these very cases should be operated first and questioned afterwards?

Is it purely a commercial question? Let us hope not.

Still, answer me this: The figures I have given you are not remarkable. Were you to gather statistics from Maine to California you would find, without doubt, that the mortality in cases medically treated would be very much less than in those treated surgically, even if these statistics were compiled from allopathic as well as homœopathic sources, and we all know how fatal their so-called medical treatment is. This very mortality is what has driven them to the knife; with them it is that or a funeral.

Not so with us of the "little pills." We have a better way; and this granted, why should we trail after the enemy, except that we are attracted by the flesh-pots?

Once more. Why should the honest doctor place his patient, or your patient, or my patient, or anybody else's patient, in needless peril in the face of such results as I have cited from the milder methods, which not only cure, but leave the party most concerned whole and sound?

Now for a brief *résumé* of treatment—common sense and homœopathy. The common sense part comes first: Ascertain beyond a doubt the condition of the bowels, and, if they need it, evacuate them thoroughly with enemata of hot salt water (teaspoon of salt to quart of water). When satisfied that this has been well accomplished, throw four to eight ounces of warm olive oil into the lower bowel, which should be retained if possible.

Encourage the patient to drink freely of large quantities of water as hot as can comfortably be taken; if this is made slightly salt, it is in most cases more palatable.

Tablespoonful-doses of olive oil that is absolutely fresh and sweet may be given hourly until three or more doses are taken; and when the taste is objectionable a taste of lemon or a swallow of black coffee, taken immediately following, will prevent nausea.

If nausea is persistent, I usually give *mercurius dulcis* in $\frac{1}{10}$ -grain doses hourly, or *ars.* 6x, until it subsides, and find that very often my patient will soon have a free, copious evacuation of the bowels. The remaining morbid condition will rapidly disappear under drop-doses of *echinacea* tincture, or 1x, given hourly in water; any tenderness remaining is usually cleared up with *hepar* 3x.

Aside from the adjuvants named, my remedies for several years have been *acon.*, *ars.*, *bell.*, *echinacea* and *hepar*, and I rely more on *echinacea* and *hepar* than on any other medicine. If, however, I were to take a case and find by examination that any other drug that I was familiar with was well indicated, I should give it with all confidence.

And again: If I were called to a case where I could not elicit satisfactory indications for any particular drug, as has been my experience in some instances, I should give *echinacea* and await developments. I have good reason to think that the hot olive oil and flaxseed poultices applied over the sensitive area have been of some value.

I have restricted my cases, during treatment, to liquid diet—soups, broths, gruels, milk, milk and egg custards, and the like, until well; and I have never, never had a recurrent case in a patient who had been strictly observant and obedient to these directions.

A CLINICAL STUDY OF DIPHTHERIA. TWO THOUSAND AND NINETY-THREE CASES TREATED AT THE BOSTON CITY HOSPITAL.—Dr. F. G. Burrows, from his experience in treating over two thousand cases of diphtheria at the City Hospital in Boston, has found the mortality to have fallen from 45.2 per cent. to 12.23 per cent. He uses the antitoxin as early as possible, in large doses and often, chiefly every four hours, as long as necessary. As a stimulant, alcohol and rarely *digitalis* was employed, which former was generously given. If the kidneys failed, he employed hot packs and the sulphate of magnesia. Patients who had been intubated were fed in the sitting position with an œsophageal tube; in case of obstinate vomiting they were nourished by rectal injections.—*Centralblatt für Chirurgie*, No. 16, 1901.—(The profession is coming to use antitoxin in large doses and often. The danger seems to lie in delay and using too small doses.)

THE DIETETIC TREATMENT OF THE DISEASES OF INFANCY AND CHILDHOOD.

BY C. SIGMUND RAUE, M.D.

Visiting Physician to Children's Homœopathic Hospital, Philadelphia.

(Read before the American Institute of Homœopathy, June 21, 1901.)

THE subject of infant feeding will ever remain in a state of confusion and a matter of personal opinion much at variance among the members of the profession so long as the principles upon which artificial feeding alone can rest, namely, to supply a substitute to the child resembling in its chemical composition mother's milk; to furnish it in an absolutely pure and uncontaminated condition, and to feed it in the proper amounts at regular intervals, are not conformed with. It is only upon these principles that artificial feeding can be logically carried out and the very best results obtained.

In abnormal physiological states, however, or in the presence of actual disease, the subject assumes an entirely different aspect, and feeding must here be conducted according to the precepts of physiology that govern dietetics in general.

Naturally the best food for infants is mother's milk. When that cannot be supplied, the next best food is one conforming with the principles above enunciated. Whether this be in the form of modified milk or any other substitute-food matters little so long as the principle is not violated. This, to my mind, is the sum and substance of the subject of artificial feeding. For this reason one clinician will obtain the best results from one method, and another from an apparently widely different one, but an analysis of the modes of procedure always demonstrates that, if the child has been a healthy one and has progressed in a normal manner, the true principles have not been violated.

When an infant fails to digest breast-milk, or does not thrive on it, before condemning the child's gastric state we should first examine the milk. Under all conditions when the food disagrees it becomes imperative to institute microscopical examination and clinical analysis of the milk in question. This is by no means so complicated a procedure as is generally sup-

posed, being in nowise more troublesome than a urinary examination. The information sought need be no more than an estimation of the fat and proteid percentages, just as urine analyses as daily practiced are no more than estimations of the urinary elements. The microscope shows the fat globules, whether perfectly or imperfectly emulsified, besides revealing the presence of cholestrum corpuscles in excess, or microorganisms when either of these conditions prevail.

The apparatus necessary for such an analysis is a lactometer or small hydrometer for obtaining the specific gravity; a Marchand lactobutyrometer and a breast-pump. After obtaining the specific gravity and the percentage of fat the proteids are estimated by comparing these two figures. For example, if the specific gravity be high and the percentage of fat also high, we may know that the proteid percentage is above normal. With low specific gravity and normal fat percentage, the proteid percentage will be low. In other words, excess of fat tends to lower the specific gravity, while excess of proteids tends to raise it. Accepting 1031 as the average normal specific gravity, we have a convenient basis whereon to make our calculations.

Having now determined whether the milk is suitable or unsuitable for the infant, we may know whether the child's stomach will need treatment, or whether a change of food is necessary. Should the milk be too poor in proximate principles another food must be chosen, unless we can build up the mother's condition sufficiently to cause her to secrete a better milk. If, however, the milk be normal and the fault lies with the infant's digestion, treatment must be directed toward this. If remedies fail to correct it, the feeding should be interrupted by alternating some readily digested food, such as albumen-water or peptonized milk with the breast.

The same principle holds good in artificially-fed children. When a food which represents the normal food for a child of a given age disagrees, the digestive function is at fault, and requires medical treatment. Lavaga is frequently of decided benefit. The food may be weakened by reducing the percentages of the ingredients, or it may be administered in smaller quantities or at longer intervals. The procedure must always remain of an experimental nature, and the results are more or less empirical.

When an inflammatory condition is present the digestive function becomes naturally so perverted that feeding must be carried out upon an entirely different plan. In gastritis, milk is usually not tolerated, and in high-grade intestinal inflammation its curds only aggravate the condition. It therefore becomes necessary to select a food devoid of curd-forming elements, which may at the same time be soothing to the alimentary tract. Albumen-water and barley-water admirably furnish the requirements. Beef-tea, while often acceptable and a stimulant, must not, however, be relied upon as a food, for its food-value is quite low.

In infectious conditions, the first result to be desired is to get rid of the offending micro-organisms. The gastro-enteric infections of childhood are due to a class of germs which thrive well in a pabulum of milk. For this reason they continue to propagate in the intestinal canal if a milk diet is persisted in. A starchy pabulum, however, is unfavorable to their existence. Therefore, the substitution of barley-water for a period of twenty-four hours furnishes one of the most efficient means of getting rid of them. If remedies are at the same time administered to control the inflammatory disturbances in the bowels, a speedy recovery may be anticipated. At the end of the twenty-four hours milk may be gradually added to the dietary, beginning with a teaspoonful in each bottle of barley-water. At the next feeding, two teaspoonfuls in each may be added, and so on, until the regular proportions indicated by the child's age are again attained.

When gastric symptoms predominate albumen-water is preferable, as it is more acceptable to the stomach, and, being an albuminous food, is not so likely to irritate the stomach as a farinaceous food, which is not digested in the stomach.

During the period of infancy, unless the babe receives a suitable supply of mother's milk, it becomes necessary to guard against the development of rickets or scurvy by not restricting the food too closely to a milk diet. This is especially so when a proprietary food is used, or when the milk is rigorously sterilized. Even in breast-feeding there is danger of rickets or scurvy occurring when the babe is kept at the breast beyond the regular nine-month period; for after this time, in the majority of cases, the milk deteriorates in quality, and does not furnish sufficient pabulum for the growing organism.

The juice of an orange or other fresh fruit, given in teaspoonful doses daily or several times weekly, together with beef-juice administered in the same manner, are the surest prophylactics against these constitutional disorders, which undermine the health and carry off in such large numbers the unfortunate victims of faulty dieting.

Other foods besides milk that are permissible after the sixth month of infancy are the various cereals. They are best prepared as a thick jelly, which may be added to the milk. Anywhere from one to four teaspoonfuls may be added to each bottle, according to the age of the child and state of its digestion. In diarrhœal diseases rice paste is especially beneficial; it should be tried if barley-water is rejected or does not improve the child's condition. The reason for withholding farinaceous food until the middle of the first year of infancy rests upon a purely physiological principle, namely, the imperfect development of the organs controlling the digestion of starch.

When infants are unable to digest the casein of milk, even when properly modified, it should be partially peptonized. In acute indigestion it may become necessary to completely peptonize the milk. The peptonizing of milk is a process so well known that I shall not enter into a discussion of it here. A valuable point, however, to remember is that the entire contents of a tube of peptogenic milk-powder—five grains of extractum pancreatis and fifteen grains of sodium bicarbonate, the quantity required to peptonize a pint of undiluted milk—is usually more than is necessary to peptonize a pint of infant's milk, as this is always well diluted. Thus, in feeding a mixture of one part milk and two parts water, a third of a tube will represent the necessary amount of extract. For partial peptonizing even a smaller quantity may suffice.

During the second year the child should receive five meals daily, and until the eighteenth month three of these should consist of milk, to which a thin porridge may be added. Although a child at this age can usually digest plain milk, still it is more beneficial to select a milk rich in cream and dilute it one-third with water. A soft-boiled or poached egg and some stale bread and a small cup of milk may be allowed for breakfast, and at dinner either beef-juice, chicken- or mutton-broth, with rice, can be added to the dietary. The juice of fruit may also be given at dinner.

It is better to wean the child from the bottle as soon as it can be taught to drink from a cup, as this lessens the danger of infecting the alimentary tract.

During the third year four meals daily are in order. At this time the child can gradually be accustomed to table food. Meat once a day is allowable in small quantities. It should be scraped or finely cut. Ham, pork, sausages and fried meats are to be avoided. As to vegetables, the majority are permissible, excepting potatoes to excess or fried; cabbage, raw celery, cucumbers, green corn, and the like.

The diathetic diseases are especially influenced by diet. Rickets and scurvy have been referred to. In the rheumatic diathesis especial care should be exercised to exclude proteids in excess. Where uric acid is formed in excessive amounts, not only the proteids, but also starch and sugar, must be cut down as far as possible. A common fault in the care of children is to give them too little water to drink. Attention to this point alone would bring as much success in many instances as the regulation of the diet. Fruit, in particular the acid fruits, are of great benefit to such children.

In the scrofulous diathesis, the great need of the organism is fat. It should be supplied in every available form, either as cream, cod-liver oil, olive oil, or oil inunctions. As they grow older they should be encouraged to eat butter freely, and occasionally the fat of meat.

In tuberculosis of the pulmonary variety the same holds good. But as the process is an active one, with rapid emaciation, the child should be given as much food besides as its stomach can dispose of. Milk and eggs are most suitable for this purpose. For the anæmia, beef-juice is to be recommended above the proprietary foods in the market. Whenever a food can be prepared at home it should always receive the preference to proprietary articles. The physician should thoroughly acquaint himself with the mode of preparation of the various foods that are required by the sick, and stimulate the home preparation of clean, fresh, wholesome articles, the composition and action of which he exactly knows, instead of relying upon the manufacturing chemist to supply him with easy, questionable substitutes.

THE HEAT CASES AT HAHNEMANN HOSPITAL, PHILADELPHIA.

BY WESTON D. BAYLEY, M.D.,

Junior Neurologist, Hahnemann Hospital, Philadelphia.

DURING the humid months of July and August it is common for us to have, besides the average run of heat cases, several days in succession when thermo-pathology assumes the proportion of an overwhelming endemic. The emergency is usually sudden, and the resources of our hospital are taxed to the utmost, at times, to properly meet it. These are days when the temperature mounts to unbearable altitude, and high humidity impairs that saving factor of hot days, the rapid dissipation of perspiration.

The three initial days of this month have been examples of this; and in that period our hospital admitted and treated more heat cases than any other institution in the city excepting the Pennsylvania Hospital, whose number of cases we about equalled.

As these cases fell under my charge during their entire stay in the hospital, I have been requested by the editor of the *HAHNEMANNIAN MONTHLY* to prepare a paper on this subject, and in this I have been greatly assisted by the Senior Medical Resident, Dr. H. B. Barclay, to whose untiring service, as well as that of the entire resident staff, many of the stricken are indebted for their lives.

The receiving ward records show that 125 heat cases were admitted during this period. These records fall short of the actual number, for there were times when cases were being brought in such numbers, and with such pressing need for prompt relief, that all hands would be employed, and record taking was temporarily suspended. About 20 per cent. of the total were thermic fevers; the remaining 80 per cent. simple heat prostrations, so-called, but frequently complicated with other conditions, as will be hereinafter shown. Four cases not included in our records were dead when brought into the receiving ward. During this period we had four deaths, one a man æt. 60, unconscious, temp. 110° axillary, hemiplegic, obviously

a cerebral hæmorrhage. Man, æt. 50, uræmic—albumin and casts in the urine. Man, æt. 38, axillary temp. 108° , died in the bath. Man, æt. 74, brought in, quickly recovered consciousness, temp. sub-normal, pulseless from admission, died in two hours.

Of the recorded cases there were 90 males and 35 females, with surprisingly few children. The greater number of women, and all of the children, were received in the latter part of the humid weather. This is to be accounted for in two ways: first, women have less tendency, and perhaps less occasion, to use alcoholic stimulants; and, second, their occupations are less taxing than is the case with men. The great bulk of the cases were men employed in hot foundries, or working directly in the sun as roofers, bricklayers, etc. A very great majority had the odor of alcohol on their breaths; so general is this, that the use of beer and whiskey is believed to be a very influential factor in precipitating the trouble. Most of the cases, both of thermic fever and of prostration, were unconscious on admission, or had been so when picked up. This loss of consciousness came on abruptly and without warning, so that their particular occupation is the last thing remembered when they would awake, confused and astonished, in the hospital. The patients are carried in either limp, as if they had been felled by a single blow; or, more particularly in the severer cases, there is a kind of myotonic rigidity of the limbs, as if the muscular tissues had temporarily undergone a coagulation. This sometimes resembles a kind of rigor mortis, and may be preliminary to severe convulsive seizures.

In the thermic fevers (that is, the cases with a temp. above 102° and up to 112°) unconsciousness is complete, and lasts from one-half to twenty-four hours. The cornea is insensitive, the eyes rolled up, with markedly contracted, even pin-hole pupils. There is snoring respiration; the surface of the body is usually hot to the touch, the pulse either full and bounding or slow and irregular; oftentimes a turgid venous hyperæmia of the face, with bluish and swollen lips—in other words a complete vaso-motor paralysis. What clear and unmistakable indications we have here for treatment! That we can, as our experience proves, reduce the mortality of these seemingly frightful cases to almost zero in those uncomplicated by previously existing

serious organic disease, is a credit distinctly due to modern hydrotherapeutics. Furthermore, that our death-rate in these cases is lower than that of any other hospital in the city is, in addition, clearly owing to the avoidance of meddlesome drug-ging and to the employment of the therapeutic methods of Samuel Hahnemann.

Each case, upon its entrance to the hospital, was divested of all clothing; the vital organs, particularly the heart, the quality and rate of the pulse, were examined; the temperature (mostly axillary) was taken, the mental condition noted—whether drowsy or completely unconscious and irresponsive to physical stimuli, or else violent, aggressively combative and wildly destructive, seemingly possessed of strength beyond that which tallied with their muscular development.

The ice-bath was used in every case which presented one or the other of two indications—first, hyperpyrexia; second, mental derangement, whether it was unconsciousness, slight delirium or violent acute mania, and these latter cases without reference to temperature. This ice-bath is the great saver of lives, and, in my opinion, the physician who does not employ it as a chief measure in his heat cases, and an indispensable adjunct in his continued fever cases, misses a most powerful factor in reducing mortality.

For the thermic fever cases, and the heat prostrations which are either unconscious or delirious, the bath-tubs are half-filled with ice-water, in which are chunks of floating ice to maintain equality of temperature. The patients are either placed naked and without ceremony directly in this bath, or else, in the case of semi-conscious and frightened women and children, lowered in on a sheet placed across the tub. Now for the vital adjunct to the cold bath, so frequently forgotten or overlooked: that is the vigorous rubbing of every part of the body under the water by the bare hands of the nurses and attendants. This treatment, that is, the combined cold water and vigorous friction, not only reduces the temperature of the overheated body by its athermic influence, but, what is more important, it revives the activity of the vaso-motor nervous system, restoring tone to the superficial vessels; it stimulates the action of the heart, preventing “failure” of it (so many, inexperienced with hydrotherapy, theoretically regard weak heart

as a contra-indication to cold water). Secondly, the central vaso-motor system, often paralyzed in thermic fever, is called into activity, thus not only bringing the overheated blood to the surface to be cooled, but positively and promptly increasing the elimination of morbid products by the skin, kidneys and lungs. It effectually, as the patent-medicine man would, with vague but impressive wisdom, have it, "purifies the blood."

With five to fifteen minutes of such a bath, with the constant and active friction—three or four or five rubbing at the same time (this must never be forgotten)—the author has seen consciousness immediately, in less than a minute, even, return to those irresponsive to any other stimuli, and quietude at once replace a violence which required the combined muscular force of a half-dozen attendants to effectually control. Delirium has ceased at the first contact with the cold water, not to return. No medicine, however completely indicated, can be compared with the ice-bath in the almost unfailing certainty and promptness of result. Yet at the same time, in some of the cases, are medicines necessary and not to be overlooked. The patient, perhaps deeply unconscious or violently pugnacious, when given his bath, recovers normal consciousness, is quiet, but has a headache of throbbing character; there is photophobia; a desire to have the head elevated; a flushed face, with throbbing vessels. In such a case it would be retarding convalescence not to give belladonna. Perhaps the patient, taken from the bath, is somewhat cyanotic; especially is this likely to be the case when repeated baths are necessary. The muscles are rigid and contracted. Here is indicated, first, vigorous friction with the hands of the attendants outside the bath; then, perhaps, hot bottles to the extremities, with ice-bags to the head, and either aconite or camphor or glonoin, according to circumstances.

Again, some of the cases are accompanied or followed by vomiting, abdominal pain and diarrhœa. Two of these symptoms may be conservative measures on the part of nature to mechanically relieve the gastro-enteric system of some material which is in flagrant violation of mankind's summer-time physiology and hygiene; these may be, for purely mechanical reasons, accompanied by the third symptom of pain. Nature may be here aided by arsenicum, veratrum alb., podoph., or

even cuprum. The writer has seen what seemed to be unmistakable benefit from the use of these remedies. The bad cases, which do not react to the bath, should be promptly catheterized, and the urine examined both chemically and microscopically.

When case after case of heat exhaustion or sunstroke is being brought in, one may overlook the fact that all of the other accidental diseases which at other than overheated times are brought to the hospital are still in evidence, perhaps in slightly increased proportion. The cases of uræmia, cerebral hæmorrhage, embolus and thrombus, the diabetic comas, the opium and other narcotic poisonings, must not be carelessly classed with the predominating instances of heat prostration which pour in from every source. The sufferers from chronic, even though it be subjectively latent, organic disease, of the kidneys or heart particularly, are susceptible in increased degree to heat stroke, and thus is added a complication which seriously affects the prognosis and materially influences the treatment. The organic lesion, in these cases, must furnish the keynote of therapeutic procedure; and, of course, this presupposes a diagnosis of the primary factor at work. There is an indescribable something about a case of uræmia which differentiates it, to the skilled observer, from the sudden yet functional unconsciousness of thermic fever or severe heat prostration. If this "something" is not apparent in at least an uneasy subconscious cognition, examine the catheterized specimens of urine in these severe and irresponsive cases. The finding of much albumin, casts and renal débris will place the case in another category. Again, the weakness of heat troubles is never of hemiplegic distribution; neither are, in the author's experience, the convulsive seizures which so often accompany or follow the hyperpyrexia. Hemiplegic spasm or paralysis, therefore, should lead to special neurological investigation; and thus a case of organic brain disease may be found either merely contemporaneous or actually co-existing with the prevailing thermic affection.

These compound maladies must be treated on purely individual principles, according to the predominance of the symptoms of this or that lesion, and with a due consideration of the possible consequences of the ordinary treatment of, for instance,

that of thermic fever upon a possible case of fresh cerebral hæmorrhage or acute Bright's disease. Thus is necessary a careful scrutiny of each severe case; an alert judgment, unbiased by the mere prevalence of heat cases; an individualized consideration of the graver and irresponsive thermic, as well as the cases in which thermic fever or heat exhaustion is complicated by pre-existing organic disease. In uncomplicated thermic fever, unconsciousness may persist, rigidity or convulsive movements may continue, and the general appearance of impending death prevail for, in the writer's experience, three to twenty-four hours, in spite of reduced temperature and the continuance of other measures of treatment; and then such a patient, hitherto apparently moribund, will, as a rule, suddenly regain consciousness, and give other indications of convalescence. This experience is important from a prognostic point of view, and it should impel us not to surrender as hopeless even the most desperate-looking and otherwise unpromising case of uncomplicated heat-produced affection of the central nervous system, until death actually ensues. The heart is not affected in the proportion that one would *a priori* suppose. The writer has had but very exceptional occasion for alarm on this account. He has in no case found it necessary to prescribe alcoholic stimulants. Strychnia, so highly lauded and freely used by the old school practitioners, has not seemingly been indicated nor employed. The same may be said of digitalis. In the few cases of circulatory depression following one or repeated cold baths for a dangerous hyperpyrexia, a physiological dose of atropine has produced prompt and unmistakable effect.

When removed from the bath, the patient, particularly if suffering from thermic fever, was wrapped in a sheet wrung out of ice-water and put to bed, one or more ice-bags being applied to his head. He was carefully watched for reaction, and in fifteen minutes the temperature taken. If this was above 102° an ice-water ablution was given, and, if necessary, repeated. If hyperpyrexia remained or returned in spite of this, the tub bath was repeated one or more times.

Infusion with normal salt solution was practiced in several of the cases in uræmic coma. In one case of a woman, æt. 35 years, who was in coma 80 hours, with repeated and severe

convulsions, the urine showing a large quantity of albumin with epithelial and granular casts, recovery took place after the abstraction of a quart of blood from one arm, and the infusion of three quarts of salt solution into the other. This patient is now rational, and, for her disease, in a fairly good condition.

Convulsions were present in about ten of the cases, and were in some severe and repeated. In these instances the tetanus-like rigidity of the muscles was almost invariably present; and, I may add, these cases were mostly in alcoholics.

The diet was a very important part of treatment. At first, liquids—milk, broths, etc.—at two- or three-hour intervals. As soon as the temperature was below 99°, and in the absence of other contra-indications, they were placed on a full diet of solid food.

This account of the cases and their treatment during the recent hot weather is about descriptive of our average summer experience. This season there were more cases than usual, but their character and the results of treatment have been about the same. The most active experience the writer has ever had in this line of work was three years ago, when, during a Grand Army celebration and parade, he admitted, and, with a large corps of assistants, personally supervised the treatment of nearly five hundred cases in one day. The hospital, dispensary and college buildings were filled to overflowing, and blankets were spread the entire length of the north walls of the buildings. On that occasion there were no deaths. This experience was unexpected and unprepared for, and it was remarkable how quickly a methodical and systematic plan of management was taken up by a previously unorganized corps of doctors and nurses, so that the emergency, unprecedented in the history of any hospital of this city, was met and managed without a sign of confusion and excitement, and, as already stated, with no mortality.

EDITORIAL.

THE INSTITUTE MEETING AND SOME INSTITUTE MATTERS.

THE Richfield Springs meeting of the American Institute of Homœopathy is now a matter of history. Those who attended the same are unanimous in expressing their satisfaction over its results. The scientific proceedings may well be characterized as of a higher standard than those of any of its predecessors. This, however, is, in our opinion, not the result of any prearranged plan or by-law governing the presentation of papers and discussions, but rather of the independence of authors in selecting subjects concerning which they had had practical experience. Years ago, the practice of the organization was that each section should present some one subject for discussion. Each member of the section was assigned some particular branch of the same, and the result was a symposium entirely unfitted for reading before a society, although in the highest degree instructive for reading or study in the quiet of one's office. Although the rule requiring papers of this character has long since been relegated to the background, there is a general feeling that it is still in force. Hence, bureau chairmen have permitted themselves to be handicapped very seriously in the presentation of their reports. This year exhibited more of a tendency than ever to break away from this custom, and the result was better papers.

The general sentiment against lengthy papers was, as a rule, respected. Indeed, we might say that long papers were noteworthy for their absence. At the same time it is well to remember that the craze for short papers can be overdone. Brevity, after all, is but a relative term. Some authors can bore an audience in a five-minute essay, while others can read for half an hour,—yes, for an hour,—and be so instructive and entertaining as to make us feel sorry that they are through. Nevertheless, it is a wise plan to keep the importance of brevity ever before the essayists.

Of the remarks made in discussion we can only speak in praise. The perennial crank who constitutes himself the carrier of precious knowledge to mankind, and who, in the performance of his self-imposed duty, goes from one sectional meeting to another, getting off the same remarks in each, stayed at home,—at least he did not make his presence felt. The individual who talks much, knows nothing, and says little, was also noteworthy for his absence. We hope he is dead.

The present rule which limits discussions to five minutes each is a good one, as a speaker who manages himself properly can generally say all that is necessary in that relatively short space of time. Though the rule may do an injustice in some cases, it is invaluable in putting a quietus on men who never know when and how to stop talking. Many debaters waste much valuable time in apologizing at the start for having nothing to say; then they proceed to waste five minutes in saying it. By that time they get an idea, and their real talk begins. We observed none of this genus at the meeting; but they will appear from time to time.

One of the greatest problems that came before the Institute was the selection of the place for the next annual meeting. No one seems to have formulated any definite ideas on the subject, and the association was not able to decide intelligently. There were some who were very strong in expressing their feelings in favor of “a quiet summer resort” where the members could all be under one roof, and apart from the rest of the world, and there were others who did not hold this view.

In favor of going to a summer resort it was claimed that the members could all be together in adjacent hotels; that there were no outside attractions to lure the pleasure-seeking element away from the meetings. To our way of thinking, these advantages do not outweigh the disadvantages, which may be stated as follows: With the present size of our National body, no place can entertain us to our advantage that has not a hotel capacity of at least 2500. If any resort can support such a crowd, it must have attractions. Hence, the members who are inclined to seek pleasure in “picnicking” will always find abundant opportunities for doing so. We admit that it is very pleasant to be housed together. But in a summer hotel this is done to great disadvantage. A series of hotels is opened say a

week or so ahead of the season for our accommodation. Without any preliminary organization of the employees, the proprietors are suddenly face to face with the problem of running to their full capacity. The result is imperfect service. And this is the case every time the experiment has been tried.

Large places, on the other hand, present hotel accommodations nearly always running with their full force of employees, hence maintaining a good organization nearly the year around. They are constructed for business.

Of as much importance as the accommodations is the ease of access. Here was the great fault of Richfield Springs. To reach it, members were obliged to stay an hour or more at Richfield Junction, a place consisting of a country tavern and a few sheds. There were other delays as well, *e.g.*, at Binghamton. Moreover, it was reached by but one road.

The question of the next place of meeting was finally left with the executive committee, with instructions to decide the matter at an early date, some time in October being suggested.

Of the attendance at Richfield Springs not much can be said. The registrar in his official report stated that it was the smallest meeting in ten years. What was also apparent was the scant attendance at the sessions. Thus, out of a total registration just short of 300, and on the day of the annual election, when 255 members voted, there were but 60 members present at the general meeting of the Section in Clinical Medicine,—the section in which one would presume the most members would be interested.

The number of new members added was disproportionately large to the attendance, being 212, which is the greatest number added at any one session. This fine showing was in great part due to the energy of one man, who of himself secured over one-third of this number,—we refer to Dr. J. B. Garrison, of New York City, who proposed no less than 81 physicians for membership. Many of the balance came in as a result of the systematic canvass of the country by a specially appointed committee. Had this committee not been handicapped by the poor railroad facilities of Richfield, we doubt not that the number of new members added would have been over 500.

Of late years there has been considerable quiet talk over the fact that each president appoints the committees and chairmen

for his successor. In other words, he is obliged to work with "a cabinet" not of his own choice, but that of his predecessor in office. He himself can contribute to but a limited degree to the success of his meeting. The manifest injustice of this is becoming more and more evident; but thus far we have known no one unselfish and patriotic enough to forego the privilege of nominating the committees, in order to rid us of this relic of bad society legislation.

For several years back it has been evident that our present organization had outgrown its usefulness. The special societies were encroaching upon the Institute's prerogatives—not that we blame the members of these societies, for they were forced to it by the inadequate facilities afforded them by the Institute programme. This year a large committee composed of men of judicial minds was appointed to study the question of reorganization, and the result of their deliberations was such as to contribute greatly to the future strength of the Institute. The idea of the reorganization plan is that we shall have one central body which shall consider only matters pertaining to legislation and general business, and materia medica with some sessions pertaining to clinical medicine. The mornings will be taken up by the proceedings of the central body, while the balance of the day will be assigned to the different sectional meetings, which for all practical purposes will be conducted as special societies. Under this plan the separate existence of the special societies is no longer necessary, or even advisable.

We trust that future executive committees will restore the evening sessions. As we have said before in these pages, this portion of the twenty-four hours is the one in which we can count upon the largest attendance; and, besides, if the three or four evenings wasted in entertainments are devoted to business, we can adjourn a day sooner than is now customary; and this is a very important matter for busy men.

Of the new officers of the Institute we can speak in the highest praise. The President-elect, Dr. J. C. Wood, of Cleveland, is a man of high literary attainments, his professional ability is a matter of world-wide fame, and he is a gentleman in every sense the word conveys. His very presence carries weight.

The new General Secretary, Dr. Charles Gatchell, has already made for himself a reputation in both medical and gen-

eral literature. He loves work for the pleasure work gives him. His executive ability and untiring energy will add greatly to the success of the Institute.

Of the Vice-Presidents, Dr. E. B. Hooker, of Hartford, and Dr. E. Z. Cole, of Baltimore, we may say that they are successful and popular practitioners of medicine in their respective communities, and receive the full confidence of all with whom they are brought in contact.

Dr. Wilson A. Smith, of Chicago, was re-elected Recording Secretary, a compliment to the efficiency with which he has performed the arduous duties of the office for the past two years.

Dr. T. Franklin Smith, of New York, was re-elected Treasurer; and may the time come to him, as it did to his predecessor, Dr. Kellogg, when he and we shall hear a colleague rise to "move the twenty-fifth annual re-election of T. Franklin Smith for Treasurer."

THE ETIOLOGY OF HEPATIC CIRRHOSIS.—It is perhaps a misfortune that interstitial hepatitis ever received the name of "cirrhosis," and still more that this title should have been so closely associated with the hob-nail or gin-drinker's liver, as it seems difficult to get a discussion of the whole subject on a broad basis. Prof. Thomas Walley has seen a typical gin-drinker's liver from the body of a young bullock, which even Sir Wilfred Lawson would probably not suspect to have been of intemperate habits; and yet there is a firmly-rooted belief that alcohol is practically the sole cause of cirrhosis of the liver. But a vast amount of evidence has accumulated that indicates that interstitial hepatitis may be *toxic*, the result of many poisons either taken into the body as food or drink, or by the use or abuse of drugs; or *infective*, due to the local action of parasitic organisms from actual infection spreading from the bile ducts or in the stomach or intestine, or more remotely from a general infective process, such as scarlatina, diphtheria, or malaria. It is probable that the disease arises from a great variety of irritants whose action upon the liver is only indirect, and that their primary effect is to cause gastritis, following which, fermentative poisons are formed in the stomach and intestine, and absorbed into the portal circulation. It has been suggested that the immediate agents in the production of cirrhosis are micro-organisms, and that the various irritants act by reducing the vital capacity of the liver, so that it is no longer able to destroy the microbes reaching it from the intestine. Adami has shown that dead specimens of the bacillus coli may be found in any section of normal liver, but in the cirrhotic liver these organisms are not only present in numbers but are full of vitality.—*Brit. Med. Journ.*, June 15, 1901.

GLEANINGS.

HEPATIC INADEQUACY AND ITS RELATION TO IRREGULAR GOUT.—Yeo, in an address to the Balneological and Climatological Society of Great Britain, insists that in the chronic ailments which we are accustomed to recognize as cases of "irregular gout," the clinical evidence, both with regard to the symptoms and the results of treatment, points to hepatic inadequacy as the initial cause. Clinical evidence is opposed to the conclusion that all or the greater part of the phenomena of gout are the result of uratic precipitation in the tissues, nor has he been able to find any sound clinical basis for the doctrine that sodium salts are injurious to gouty persons and that alkalies are useless in the treatment of gout. He questions whether all the physicians in the world have been wrong in sending their gouty patients to drink alkaline waters rich in sodium salts. He does not, as the chemical argument seems to assume, give sodium salts and other alkalies in the belief that they dissolve uratic deposits in the body, but because they are most useful in promoting the healthy function of the liver and in favoring metabolism generally. The remarkable action of the sodium salts on the hepatic functions is shown by their curative effect in "gouty" and dietetic glycosuria, in which the remedial influence of Carlsbad, Neuenahr and Vichy cannot be disputed, and we have all seen numerous instances of their remedial action in other so-called "gouty" disorders. Both Lyman and Bouchard call attention to the close relationship between gout and biliary lithiasis, and the value of sodium salts in the treatment of the latter cannot be questioned.

Of symptoms referable to hepatic inadequacy presented by patients with irregular gout, he mentions that the *fæces* are often pale, from the absence of biliary coloring matter, and are often very offensive. Enlargement of the liver can frequently be made out. The complexion is often muddy and the conjunctiva yellowish, and the patients often complain of a sweetish bitter taste in the mouth and loss of appetite. The urine is high colored, of high specific gravity, extremely acid, and gives with nitric acid the color reaction which we associate with disordered hepatic function. It seems to him, so far from the kidneys being functionally diseased in these cases, as has been suggested, they really eliminate excrementitious substances that are normally excreted in the bile, and hence this color reaction.

There are physiological as well as clinical reasons for incriminating the liver in the production of the gouty state. We know that the liver is specially concerned in the metabolism of carbohydrates—its glycogenic function—and also in the metabolism of nitrogenous material, the formation of urea and uric acid. We know also that in the gouty one of these functions—the glycogenic—is often disturbed, and is restored by alkaline medication; is it not reasonable to conclude that another function of the liver, carried on side by side with this one, is also prone to be disturbed? for clinically we see it re-

stored by the same means. In conclusion, Prof. Yeo suggests that the safest diet for these patients is the simplest diet. It is a mistake to dogmatize; we must study their individual dietetic capacities.—*Brit. Med. Journ.*, June 15, 1901.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF CIRRHOSIS OF THE LIVER.—At the recent meeting of the American Medical Association, Musser, of Philadelphia, spoke on this topic. He divided the cases of cirrhosis of the liver into those in which no symptoms occurred during life,—the cirrhoses having been found at autopsy, the patients dying from other causes—into those cases that were not suspected until such an accident as hæmorrhage made them apparent,—that is, latent cirrhoses; and into cases with the symptoms of portal obstruction, and, on the other hand, biliary obstructions. The lines of treatment were largely dietetic and hygienic, great care being taken to see that the functions of the gastrointestinal tract were kept in action all the time, and that renal and skin excretion were properly regulated. He raised a word of caution as to the presence of hæmorrhoids; many patients were operated upon without careful investigation, and it had been his misfortune to see two or three deaths follow operative treatment when, at autopsy, cirrhoses of the liver were shown to be present. In all cases of hæmorrhoidal disease a thorough knowledge of the state of the liver should be secured before any operative measure is advised.

The management of ascites occurring in cirrhoses is interesting because of the late attempts at treatment through surgical intervention. In the treatment of ascites there were medicinal and surgical measures. He was accustomed to the use of mild purgation, and from time to time he gave calomel in $\frac{1}{40}$ gr. doses every three hours as a diuretic. He also relied upon the old-fashioned pill of digitalis, squills and calomel, and he had considerable confidence in the oil of copaiba. In any case of ascites he did not wait long to determine whether these drugs would be of use, but resorted to tapping early and often. One should not be appalled at the frequency of tapping required in these cases. One case was cited in which tappings were done 190 times. He then considered the question of permanent drainage, and stated that Dr. Frazer had operated upon a case, opening the abdomen, scarifying the peritonæum, and attaching the omentum to the abdominal walls; this was done twelve months ago, and the patient is cured of his ascites. Among 20 cases operated on in Philadelphia, a very large percentage was relieved or cured.—*Boston Med. and Surg. Journ.*, July 11, 1901.

F. Mortimer Lawrence, M.D.

HÆMATURIA FOLLOWING THE ADMINISTRATION OF UROTROPIN.—Brown, recalling that the use of urotropin in enteric fever has been advocated of late by several authorities, with the intention of thus preventing urinary complications as well as the spread of infection through the urine, records two cases of hæmaturia which followed the use of 10 grs. of the drug three times a day. This seems to indicate that the drug, though of undoubted value, is not quite so free from injurious effects as has been thought. In each case the hæmaturia subsided rapidly after the drug was stopped. Hæmaturia resulting from nephritis in enteric fever is not unknown, but in such cases urotropin appears to be beneficial.—*Brit. Med. Journ.*, June 15, 1901.

F. Mortimer Lawrence, M.D.

TREATMENT OF ERYSIPELAS BY LOCAL APPLICATION OF A SOLUTION OF SULPHATE OF SODA.—Dr. G. L. Curtis, knowing that the sulphate of soda has a great affinity for oxygen, used this drug in the management of erysipelas, in order to withdraw from the micro-organisms of this disease the gas necessary to their development. After having carefully cleansed the affected area, it is covered with a coarse cloth or gauze, and a thick cream of the sulphate of soda, made of the sulphate of soda and distilled water, is spread on, covering this layer with a cloth. This is wet at times with ice-water. If the face be affected, the nostrils and mouth are fitted with tubes to facilitate breathing, and a mask of this paste laid on. Six to eight hours suffice to destroy all the streptococci and to bring about a recovery. If the disease relapse, make a second application. He thinks this measure might be useful in other skin diseases requiring a great deal of time to bring about a recovery.—*La Semaine Médicale*, No. 19, 1901.

Frank H. Pritchard, M.D.

DIABETES COMPLICATING SURGICAL MEASURES.—Dr. A. Zebrowski concludes from three cases that if one has to do with a wound which refuses to cicatrize, one should examine the urine for sugar, for diabetes may be the cause. This disease constitutes a serious complication of surgical intervention. It may appear during convalescence and act very unfavorably on the patient's general condition.—*Przegląd Chirurgiczny*, tom iv., zeszyt 4, 1901.

Frank H. Pritchard, M.D.

BRAWNY (LIGNEOUS) INFLAMMATORY INFILTRATION OF THE CELLULAR TISSUE.—Dr. L. Krause calls our attention to this peculiar inflammatory condition which was first described by Reclus, who observed five cases. In nearly all, it developed in the anterior or lateral portion of the neck, and consisted in an infiltration of the cellular tissue for quite an extent, which was as hard as wood. The disease will be weeks, or even months, in developing, without fever or any general symptoms. The usual signs of acute suppuration of the cellular tissue are generally lacking. For a long time the skin undergoes no modification. Suppuration only takes place after weeks. In the beginning one may confound it with a neoplasm. The writer has observed two cases.

The first, a woman of thirty-five years, eight days after the beginning of the disease noticed a tumor develop in the anterior portion of her neck, extending from the outer border of the right sterno-mastoid to the inner border of the same muscle on the left side. It reached from the lower border of the lower jaw to the upper portion of the sternum, resting on the latter. There was no general reaction. The tumor was of a wooden consistence, covered the whole front of the neck, and was seemingly uniform; its borders were well defined, the overlying skin white, not œdematous and displaceable. The growth was not sensitive. The cervical and submaxillary glands were not enlarged. On the sixteenth day of the disease the lowermost portion began to become colored and slight fluctuation was noticed above the notch of the sternum. Three days later this was incised and a half-teaspoonful of pus evacuated. The wound slowly closed and cicatrized in about a month, while the induration gradually decreased. Cultures made with the pus remained sterile.

The second case was that of a youth of eighteen years, where the tumor

was seated in the abdominal wall, extending from the pubes to the umbilicus and dating back ten weeks. After having had him under observation for several days an abscess appeared below the umbilicus which was evacuated; the pus was sterile. Only by making inoculations with liquid drawn from the non-suppurating portions of the growth were cultures of a micrococcus, arranged in threes and fours, obtained. They were distinctly and uniformly stainable. Inoculation of these germs into rabbits gave rise to infiltrations and abscesses containing the same micrococci. The wound healed entirely. The etiology of this disease is obscure.—*Przegląd Chirurgiczny*, tom iv., zeszyt 4, 1901.—(This peculiar state has been taken for a malignant neoplasm. A Russian writer last year reported such a case in an old man. The diagnosis was made by applying a poultice and causing the growth to break down in a small area).

Frank H. Pritchard, M.D.

BACTERICIDAL EFFECT OF TEARS.—In order to decide whether tears had true antiseptic properties, or whether they formed merely an unfavorable culture medium, he prepared equal quantities of distilled water and tears with a few drops of bouillon. He found that the staph. pyogenes increased markedly in the bouillon water, but died very quickly in the tear bouillon.

Boiling for four or five minutes destroyed the antiseptic effect of tears. A sodium chloride solution of 1 to 1.5 per cent. did not prevent an abundant increase of the bacteria.

The antiseptic properties of this do not depend, therefore, on the percentage of salt.

According to his views, then, tears exert a bactericidal effect on the staph. pyogenes. Boiled water used for control experiments does not. The bactericidal qualities are stronger the smaller the number of infectious bacteria.

Fresh virulent cultures offer more resistance than old ones.

The bacterial agent is destroyed by boiling for four or five minutes. It is, therefore, a volatile substance, or it is precipitated in an inefficient condition with the voluminous albuminoid precipitates caused by the boiling of the tears.

The salts do not play the deciding part in regard to the antiseptic qualities of the tears.—A. Helleberg, *Ibidem*.

William Spencer, M.D.

A CASE OF DIFFUSE KERATITIS FROM ACQUIRED SYPHILIS.—The case was that of a young man whose mother was a syphilitic, and who, in the first year of life, had survived an attack of congenital syphilis. In his twenty-second year he acquired syphilis. A very interesting point is opened up here as to whether an individual who has had congenital syphilis can be infected later. Such, certainly, was the history of the case reported by Mendel, for the patient had passed successfully through an attack of congenital syphilis, and became infected afresh twenty-one years later. Both eyes were affected with a typical diffuse keratitis. This trouble disappeared under energetic inunction. Six years later it broke out again under the guise of an episcleritis, which also disappeared very rapidly under inunction.—Dr. Fritz Mendel, *Centr. für prak. Augenh.*

William Spencer, M.D.

A CASE IN WHICH THE CILIARY PROCESSES WERE PLAINLY VISIBLE IN THE PUPILLARY FIELD.—The patient was a woman of twenty years, who

sought the advice of the author for what she thought was a cloudy cornea. It was found, however, that the whitish appearance had its seat in the lens—in other words, that she had cataract, which undoubtedly dated back to childhood. The cataractous lens had shrunken in both diameters. As a result there was a lengthening of the ciliary processes, more marked at the lower and nasal border, and less marked at the upper and temporal border.

These little prolongations lay so close together as to barely permit here and there a red reflex.

There were forty-six ciliary processes counted. It will be recalled that the text-books put the number of ciliary processes at from seventy to eighty. He considered the various methods of operating in this class of cases, and finally determined to make a small incision below. Into this wound, and up into the anterior chamber he passed a discission scissors, and simply divided the cataract, which separated each half, withdrawing to either side and leaving a large black pupil.—Professor Eversbusch, *Munch. Med. Wochenschrift*.

William Spencer, M.D.

PENETRATING WOUNDS OF THE ABDOMEN.—Russell Fowler (Brooklyn) says: "Aside from whatever injury may be inflicted upon the abdominal viscera, the mere fact that the abdominal covers have been penetrated and the cavity of the peritoneum invaded by a foreign body is of great import. The classical and time-honored custom of immediately probing wounds of this class cannot be too highly condemned. Nor should the finger be employed. Treated rationally and intelligently, in the majority of these cases the patients can be saved. There is one rule in the treatment of abdominal injuries in civil life which should be a law—*explore*."

In dealing with a wound of the abdominal wall the strictest antiseptic technique is necessary. The patient's skin is scrubbed and shaved "from the nipple line to the middle third of the thigh." It is then washed with oil of turpentine, alcohol, ether, and bichloride of mercury. That portion immediately around the wound is painted with tincture of iodine. The operator, nurses, assistants, etc., prepare as for any laparotomy. Then, and not till then, is the wound explored. The author advises the use of a probe, first, in order to determine the depth of the wound, and whether the peritoneal cavity is entered or not. It should be the rule to enlarge the wound and examine carefully for any rent in the peritonæum. If there is none, and the structures underneath appear normal, no harm has been done, and the wound, after being disinfected, can be closed layer by layer. If, however, after thorough examination, there be the slightest evidence of the peritoneal cavity having been invaded, an exploratory laparotomy should be done at once, and the viscera carefully examined for any injury they might have sustained.

No abdominal wound is to be considered insignificant. It is impossible to distinguish between insignificant wounds and grave ones in the first few hours following the infliction of the injury. The law of immediate intervention is imperative. If multiple wounds of the abdominal walls are present, or if the nature of the injury leads one to expect multiple visceral lesions, the exploratory laparotomy should be made in the median line.—*New York Medical Journal*, June 15, 1901.

Gustave A. Van Lennep, M.D.

MENTAL DISEASES OF CHILDHOOD.—(W. B. Noyes, M.D.)—A child's life can be divided into three critical periods. (1) *Infancy*. This includes the first

three years, and has the gastro-intestinal tract for its point of least resistance. (2) *Fatigue period*, from seven to nine years, when the heart seems to be the point of least resistance. (3) *Puberty*.

As to mental disease, the first period is associated with idiocy and symptoms associated with motor disturbances, chiefly convulsions and paralyses. In the majority of instances these are reflex from gastro-intestinal disturbances.

A careful study of the *fatigue period* emphasizes the fact that the growth of the child both mentally and bodily is more or less rhythmical in its nature. Every extensive intellectual advance corresponds to a retrogression in bodily relations. As the result of such a period of retrogression the following symptoms may occur: fatigue, dulness, carelessness in all sorts of work, slovenliness, and a general reversal of the ordinary characteristics of the child. In this period the group of symptoms that occupy the nervous system consist in twitching of single groups of muscles and choreiform movements in various parts of the body. Sensory disturbances are rare. Perhaps the earliest sensory disturbance is the inability to sleep.

The period from seven to eleven has been characterized as a period of co-ordination of motion and emotion. Chorea, epilepsy, asthma, somnambulism, migraine, myopia and convergent strabismus may be mentioned as neuroses of this period.

The mental changes of the period of *puberty* are not less than the physical. The most common traits of this period may be summed up as follows:

(1) Frequent and causeless change of moods. (2) Universal mental depression during the jolliest hours. (3) Sudden changes of the habitual line of thought or incoherence of the normal thought. (4) Talkativeness, mimicry, extravagance. (5) Impulsiveness in action. (6) A sense of exaltation, and ambitious delusions of greatness alternating with feelings of depressing unworthiness. This period is called by some the "sexual period."

In a child with poor heredity and unhygienic surroundings the period of puberty is sure to develop some organic or functional disorder. The most common psychoses at this time in life are melancholias, mania with its varieties, sexual aberration, hysteria, general neurasthenia, epilepsy.

The fact is emphasized that the less pronounced physical disturbances that occur in young children are often the first manifestation of a train of symptoms that are to end in the development, some years later, of one of the definite forms of adult insanity.—*New York Med. Journ.*

William F. Baker, A.M., M.D.

THE FEEDING OF DIPHTHERIA PATIENTS, WITH SPECIAL REFERENCE TO CHILDREN AND SEVERE CASES.—(R. G. Burton).—Feeding in diphtheria may be carried out by (a) *mouth*, (b) *nasal feeding*, (c) *rectum*, (d) *subcutaneous* injections. *Mouth feeding* is the best, although there are certain conditions in which it is inadmissible, particularly where there is an inability to swallow on account of pain; regurgitation; entrance of food into the larynx, made known by persistent coughing after feeding; struggling and consequent exhaustion; continued vomiting, which may be present from the onset, or early vomiting from the second week, or late vomiting. In the early stages milk should be the chief food, and to be fed slowly. Children with regurgitation should have fluids thickened. Brandy is the best stimulant in the presence of vomiting. Nasal feeding is indicated by (a) inability to swallow either from regurgitation or par-

alysis; (b) coughing on feeding; (c) vomiting, which is relieved by nasal feeding; (d) exhaustion. All foods should be strained and given warm.

Rectal feeding should be resorted to when the mouth and nasal feeding fail or seem to be insufficient. It is indicated in cases where the nasal feeding is impracticable, in children who struggle with the passing of the nasal tube, or where the nasal tube causes bleeding from the nose. Persistent vomiting is a very important reason for the use of rectal alimentation.

Peptonized milk should form the bases for all rectal alimentations, and to these may be added white of eggs, raw meat juice and yolks of eggs. The feedings should take place once every four hours.—*The Lancet*.

William F. Baker, A.M., M.D.

TREATMENT OF PURPURA HÆMORRHAGICA BY THE INTRAVENOUS INJECTIONS OF BICHLORIDE OF MERCURY.—(Lusignoli.)—The view is strongly held that this disease is of bacterial origin, not of a specific micro-organism, but of various pyogenic bacteria. *Staphylococcus albus* and *aureus* have both been found in the blood cultures. He was led to his investigations by the success attending the intravenous injection of quinine in pernicious malaria, and also of the bichloride in syphilis and some cases of erysipelas. The injections are made daily into the basillic, median basillic or cephalic veins of 1 to 4 milligrams.

The conclusions reached from his observations are:

(a) The hæmorrhagic affections (scorbutus, purpura and Werlhoff's disease) are due to micro-organisms, the product of which penetrate into the blood.

(b) The various hæmorrhagic affections are of the same nature, only different in degree.

(c) Intravenous injections of bichloride of mercury cure the affection.—*Archives Gen. de Med.*

William F. Baker, A.M., M.D.

INTESTINAL SUTURE BY MEANS OF CONTINUOUS CATGUT STITCHES AND EXCISION OF THE MUCOUS MEMBRANE.—Littlewood (England) presents a method of performing gastro-enterostomy and enterectomy by suture alone, and without the use of any accessory apparatus. The technique of the operation is as follows:

Gastro-Enterostomy.—The selected portions of the stomach and jejunum were emptied and clamped by means of "Doyen's pedicle forceps, the blades of which are covered with india-rubber tubing." The portions of the stomach and bowel to be operated upon are placed in close apposition, and surrounded with strips of gauze or flat pads. An incision one and a half inches in length is made into the stomach and bowel, through all the coats down to the mucosa, and with a pair of ophthalmic scissors and forceps the coats all around are separated from the mucosa for a short distance, so that a broad surface may be brought into contact. With chromic catgut and a small curved Hagedorn's needle the posterior edge of the stomach incision is stitched to the corresponding portion of the bowel, and the suture tied and left long. An elliptical portion of the mucous membrane is then excised from the stomach and the bowel, and the cut edges stitched the whole way around by a continuous suture of catgut, knotting it in two places to prevent its drawing too tightly. Finally the anterior portions of the incisions into the stomach and bowel are stitched together, using the same suture which was

left long after uniting the posterior edges. No attempt is made to approximate serous coat to serous coat, but broad surfaces, including the deeper layers, are brought into apposition. The cutting and stitching require but ten or fifteen minutes. The suture prevents bleeding.

Enterectomy.—A very similar operation is performed here. After clamping the gut with "Doyen's forceps," above and below the diseased area, it is excised in the usual way. A portion of the mucous membrane from both tubes is then removed so that it retracts beyond the cut edges of the other coats. The two cut ends are approximated by the clamps and sutured by continuous catgut stitches in the same way as for the gastro-enterostomy described above. The clamps are removed and the mesentery united by interrupted sutures. The author has done three successful colectomies, and seven or eight gastro-enterostomies.—*The Lancet*, June 29, 1901.

Gustave A. Van Lennepe, M.D.

THE USE OF GELATINE INJECTIONS FOR INTERNAL HÆMORRHAGE FOLLOWING THE REMOVAL OF A LARGE FIBROID OF THE UTERUS.—(Albert.)—The patient reacted well after the operation, and received daily infusions of salt solution. The pulse remained about 100; the temperature reached at one time $38\frac{1}{10}^{\circ}$ (R.). On the sixth day the dressings were removed for the first time. The wound showed no reaction and the abdomen was soft. The compress and binder were removed, as the writer feared there was still danger from parenchymatous intestinal hæmorrhage, which is liable to follow the removal of so large a mass from the abdominal cavity. The wound healed by first intention. The patient made such a good recovery that on the sixteenth day after the operation it did not seem possible for intestinal hæmorrhage to occur. She then had profuse mucous stools, and the pulse increased to 140. The patient looked anæmic, the stools became bloody and more profuse, the pulse was scarcely to be felt, and the patient fainted. Infusions of salt solution and injections of camphor were tried without results. The writer finally tried subcutaneous injections of gelatine. One hundred cubic centimeters of a solution of gelatine in salt water, 10 : 6 : 1000, were injected. Six hours later, 50 c.c., and this was repeated twice. The bloody stools disappeared, the patient recovered, and was able to leave the bed in four weeks after the operation. The writer emphasized the fact that in similar operations the gelatine should be prepared all ready for injection, and injected at once at the first sign of hyperæmia of the intestine, such as a discharge of mucus, a sign to which the writer had not ascribed due importance sufficiently early. One hundred cubic centimeters of the above-described gelatine solution should be injected the first time, and repeated as circumstances may require. According to Lancereaux, Paris, up to 250 c.c. can be given at one time, and 50 c.c. every six hours subsequently. The use of gelatinous food has been recently recommended, but the writer considers it useless, as the gelatine is liquefied by the stomach digestion, and its specific effect, the increase of the coagulability of the blood, is lost.—*Centralblatt für Gynäkologie*, No. 16, 1901.

George R. Southwick, M.D.

A NEW CASE OF VAGINAL CÆSARIAN SECTION.—(Dührssen.)—The writer publishes the third case of vaginal Cæsarian section. The patient was a tuberculous primipara, 31 years old, who was attacked by severe eclampsia

in the seventh month of pregnancy. As the cervix was undilated, the anterior wall was split up to the lower segment of the uterus, and the child, which was in a transverse position, was delivered by combined version and extraction. The uterine cavity was tamponed after removal of the placenta, and suturing the uterus completed the operation. Eclampsia did not occur under the continued use of morphine, but the patient died on the twenty-third day from tuberculosis and the occurrence of albumin in the urine and œdema. The progress of the case, so far as the pelvic organs were concerned, was absolutely normal, and Dührssen is of the opinion that this case should be classed in statistics as eclampsia cured by vaginal Cæsarian section. He hopes to see the time when the classical Cæsarian section for severe eclampsia will be entirely replaced by the vaginal Cæsarian section. He recommends the latter in all those cases in which the life of the mother or child is seriously endangered by some great obstruction to labor in the soft parts, and by a rigid and undilatable cervix. He believes that the operative treatment of eclampsia in this way will show 93.75 per cent. of recoveries, while spontaneous delivery shows only 78.9 per cent. It also makes it possible to deliver at once a living child.—*Centralblatt für Gynäkologie*, No. 2, 1901.

George R. Southwick, M.D.

THE SURGICAL TREATMENT OF UTERINE DISPLACEMENTS.—(Reed.)—The writer recommends intra-peritoneal shortening of the round ligaments as the operation of choice for the majority of all cases of retro-displacements. A letter of S fold is made in the round ligament by twisting it with a four-pronged forceps. The fold is then stitched together.

The following is a brief outline of the operation: The ligament, brought up into the field of operation on the finger, is seized in its middle third by the four-pronged forceps, which is then turned half-round, thus effecting, by a simple twist of the wrist, the desired shortening of the ligament. It is then held in this position until all the sutures are applied. These are inserted as follows: One interrupted, one fixing the loop of the ligament to the cornua of the uterus; a similar suture is utilized to fix the outer fold of the ligament; a continuous suture is then passed between the prongs of the fixation forceps, its ends being tied obliquely after the instrument is withdrawn.

A hypertrophy of the convex wall at the point of flexure often exists in cases of long-standing flexion, and offers a persistent resistance to the maintenance of the normal axis of the organ. This is overcome by placing the patient in the Trendelenburg position, and removing a wedge-shaped segment from the hypertrophied wall. The uterus is brought toward the incision, and an ellipse of tissue one centimeter wide and corresponding in length to the breadth of the organ is removed from the convex side at the site of flexure. The dissection must not be too deep, as the circular artery or anastomosing branches of the uterine arteries may be injured. Should the latter occur, pass ligatures deep into the uterine tissue at either end of the gaping ellipse. After the hæmorrhage is controlled, the margins of the ellipse should be carefully closed by a continuous animal suture, passed deep into the matrix. The writer has treated ante-flexion successfully by stitching a reef of the posterior folds of the broad ligament to either side of the posterior surface of the uterus.—*Am. Jour. of Obstetrics*, November, 1900.

George R. Southwick, M.D.

THE TREATMENT OF GONORRHOICAL CYSTITIS BY PERMANGANATE OF POTASH.—Drs. J. Henry Carstens and James T. Jelks recommend highly the permanganate of potash for the irrigation of the bladder. Begin with a strength of one to six thousand, and inject the bladder with as much of the solution as the patient can stand, holding it as long as she can, and then voiding it. The first time the patient may not be able to stand more than an ounce. After awhile she can hold five or six ounces of it in the bladder for half an hour or longer. In a few days this amount of solution will be tolerated in the bladder without any trouble, so that the permanganate of potash can be increased from five grains to the pint to ultimately ten grains to the pint. When this treatment is carried out for about ten days the patient is cured. It is not necessary to fully distend the bladder. Sir Henry Thompson demonstrated years ago that if we wish to wash out the bladder, we should use a pint of water sixteen times instead of all at one time.—*Am. Jour. of Obstetrics*, November, 1900.

George R. Southwick, M.D.

THREE DANGEROUS OPERATIONS—REPAIR OF A LACERATED CERVIX, DILATATION AND CURETTMENT.—(Deaver.)—A lacerated cervix in women who have borne children may be considered more of a normal than a pathological condition. In the absence of special indications, such a cervix had better be let alone. If, however, a lacerated cervix be extensive enough to permit gaping of the edges and consequent exposure of the cervical mucous membrane to injury, or if ulceration be present, or if the scar tissue is hard and in excessive amount, or if any of these conditions give rise to subinvolution or marked reflex symptoms, then operation is indicated. If, in addition to any of the above conditions, there is a history of hereditary tendencies toward malignancy, we have the strongest indication for operation. A patient with a family history of carcinoma, presenting the above conditions, should be operated upon at the earliest possible moment; and this should be repeated after subsequent labors if the cervix be torn again, as it is likely to be. As strong as these indications are for operative interference, we are not justified in instituting them unless there is freedom from all pelvic inflammatory processes or their results. Salpingitis, pyosalpinx or adhesions offer strong contra-indications. Under these circumstances, abdominal section for the correction of intra-abdominal trouble should follow immediately the repairing of the lacerated cervix. If the cicatricial tissue in a lacerated cervix involve the supra-vaginal cervix, it may be sometimes impossible to remove it entirely except by high amputation of the cervix, with freeing of the bladder and rectum; if, under these circumstances, there is a history of a hereditary tendency to malignancy, or if the patient be near or undergoing the menopause, vaginal hysterectomy may be considered the more rational procedure.

Great care must be exercised in endometritis to prepare the endometrium, if this be possible prior to the narrowing of the cervical canal, so as to provide adequate drainage, or, in other words, to decrease the discharge so that the new and narrow canal will carry it off. Aseptic details in any one of the three operations are as necessary as in any in the realm of surgery.

A latent salpingitis can be converted into an active one by the introduction of sepsis through instruments or intra-uterine douching, or the spread of sepsis from an infected uterine cavity, or the breaking up of peri-uterine adhesions, liberating septic foci which have been imprisoned.

Adhesions can be torn by bringing the uterus down to the vulvar orifice. The tenaculum should not be used to make traction during dilatation or repairing the cervix, but only to steady the uterus. Washing out the uterus, except in septic conditions, and also plugging the uterine cavity with iodoform gauze, are vicious practices too often capable of exciting salpingitis.

If the discharge arising from an endometritis shows the presence of gonococci, curettement is positively contra-indicated, for it is certain that such a procedure will most probably light up an active gonorrhœa, which shows marked tendencies to spreading and consequent tubal involvement.

If dilatation of the cervical canal was not so dangerous and inefficient I might be induced to sanction it and perform it more often than I do. I would especially condemn the attempts, and I say attempts advisedly, at dilatation in the physician's office, as it is a most dangerous and useless practice. Divulsion should never be done except under complete anæsthesia, and with the most rigid observance of aseptic and antiseptic precautions, which are as important here as for a vaginal hysterectomy.

Dilatation is indicated in dysmenorrhœa due to cervical stenosis, as a preliminary step to curettement when there is a displacement of the uterus which is not adherent, and when there is an absence of pelvic or tubal inflammation, either active or latent.

Divulsion for stenosis of the cervix is at best an unsatisfactory measure, as it frequently fails to meet and overcome the condition. It is often necessary to repeat the operation several times before relief is afforded.

Dilatation as a method for the correction of flexions of the uterus must be classed among the surgical failures.

In the discussion of this paper Dr. Montgomery remarked that the operation for laceration of the cervix is one which is performed much more rarely to-day than a few years ago. He states that Dr. Emmet remarked to him recently that he very rarely found cases in which it was necessary to do the operation he had devised. The reason why we had trouble in the old cases of operation on lacerated cervix was that the increased secretion had difficulty in getting out of the uterus through the small canal, and dilatation of the uterine cavity and of the orifices of the tubes resulted, which were favorable conditions for extension of inflammation from the uterus into the tubes.

Dr. Hurst remarked that he had had a very satisfactory experience with microscopical examinations of the endometrium, and had the greatest confidence in the ability of certain trained examiners in this work to make a correct diagnosis. The primary operation on lacerations of the cervix, strictly speaking, is not warrantable if at the end of two weeks the involution of the cervix is sufficient to allow of a certain success in the repair of any injury which may have happened to it. It is an interesting question whether many of these injuries ought not to be repaired before the woman's puerperal convalescence is complete. In the hospitals under his charge he does not allow any woman to leave with an injury from childbirth, whether recent or remote, if she will consent to its repair.—*Am. Jour. of Obstetrics*, May, 1901.

George R. Southwick, M.D.

THE REMOTE RESULTS OF OPERATIONS FOR CARCINOMA UTERI.—Baldy, in a discussion of this subject, remarks that any teaching which says that more than 5 per cent. of cases of cancer of the cervix are saved is bad. It

gives the general practitioner a false sense of security; it deceives him as to his terrible responsibility in making an early diagnosis. The more he is impressed with the terror of this disease the more carefully he will scrutinize his cases and will arrive at an early diagnosis, and will insist on an early consultation even in suspicious cases. Before you can use the microscope, cancer must be suspected. If the general practitioner who sees these cases first is not thoroughly educated to make a diagnosis clinically, to recognize the early symptoms and their comparative significance and consider them carefully, we are never going to make any advance. The teaching of the laboratory is doing harm; entirely too much stress is laid on it; it is clinical observation that is going to be the salvation of these cases.—*Am. Jour. of Obstetrics*, May, 1901.

George R. Southwick, M.D.

THE TREATMENT OF PROCIDENTIA UTERI.—(Wylie.)—All operations which attach the uterus in an abnormal position are bad. Hysterectomy should be done only in very rare cases. He does not approve of opening the inguinal canal, or even the operation called by his name, as the distal ends of the round ligament are too weak to hold the organ in place. If Alexander's operation is done properly and a pessary kept in for two or three months afterwards, it gives the best results; but the size of the uterus must be reduced by treatment first. In elderly women the round ligaments have atrophied so much as to be of no use, and in such cases Dr. Cleveland recommends Le Fort's operation. Remarkable involution of the uterus takes place in procidentia if the organ is kept in place and the pelvis emptied of blood by elevating the foot of the bed.

George R. Southwick, M.D.

ATROPINE IN THE TREATMENT OF INTESTINAL OBSTRUCTION.—Dr. Rumpel, of Hamburg, in a paper read before the medical society of that city, called attention to this important measure, stating that up to date about two dozen cases have been reported, with four deaths. Not all of them reported as such could be regarded as ileus. He added two further cases to the literature:

1. A woman of 64 years, very delicate, and ill for several years from bronchiectasia, suddenly was seized with violent colicky pain, which recurred every five minutes, with sudden collapse and vomiting of feces. No doubt of acute intestinal obstruction, but the seat of the stenosis was not to be made out. The intestinal coils were visibly distended; no peristaltic movement. Urine very scanty. Morphine and flushing the colon bringing about no relief, and the fecal vomiting and colic continuing and increasing in severity, an operation seemed contra-indicated on account of the collapse and the existing pulmonary disease. Atropine was therefore injected, 1 mgm., hypodermatically, after which the abdomen seemed softer and the pains less; later, several other hypodermics were administered, in all, 5 mgms., during the course of fourteen hours. Thirty-six hours after the beginning of the symptoms flatus and hard balls of feces were passed. A rapid recovery soon followed.

2. A woman of 50 years, and very corpulent, fell ill at midday, with violent pains in the stomach; she received morphine. The following evening she was collapsed; there was acute obstruction of the intestines and distended abdomen. Opium and belladonna were given internally. A resistant spot

could be made out in the right hypochondrium. The next day the patient suffered from violent colic, increasing prostration, restlessness and non-feculent vomiting. One mgm. of atropine was given subcutaneously, followed, later, by two injections of 2 mgms. each. In twenty-four hours she had a thin and copious passage, mixed with mucus.

The writer discussed the different forms of ileus. Atropine would seem to be indicated in the dynamic or paralytic variety; in the mechanical form its use would appear less rational. Curiously enough, the maximal dose of the drug has been injected several times without symptoms of poisoning being noted. He usually begins with 1 mgm., instead of the enormous doses of other writers.—*Muenchener Medicinische Wochenschrift*, No. 19, 1901.—(I have recently employed this method of treatment with good results in a case which seemed to be one of the paralytic variety. The many favorable results reported when used in desperate cases should lead one to think of it in time of need.)

Frank H. Pritchard, M.D.

ACCIDENTS AND DIABETES.—Prof. Hirschfeld, of Berlin, observed a man who slipped on the sidewalk, injuring one of his testicles, which that night swelled. The following day he vomited violently, suffered great pain, and fell into a comatose state. Three per cent. of sugar was found in his urine. This coma lasted for ten days, to be followed by death. The necropsy revealed nothing of consequence. The case came to trial on account of a question of the responsibility of life-insurance companies involved, and the question whether the accident caused the diabetes, with consequent death, or whether the accident had aggravated an already existing diabetes. The latter was decided as probable.

The relation of diabetes to injuries as possible causes is, however, very interesting, for it may be very fully discussed in trials for damages when the question of responsibility comes up. Claude Bernard's puncture has given rise to a great deal of thought and experiment. The resulting glycosuria after blows on the head is usually temporary, though cases of actual diabetes following and caused by injuries have been observed. Unfortunately, a latent diabetes cannot be excluded, and, as is well known, certain nervous influences, as injuries, violent exertions, great excitement, etc., may bring about coma in diabetics. Gangrene may be also produced by an injury, but the (German) courts have decided that the injury must be one of some consequence to fix responsibility. The temporary glycosuria after injuries is aggravated, according to experience, by too early resumption of one's occupation. Here the question of responsibility of accident-insurance companies is involved.—*Muenchener Medicinische Wochenschrift*, Nos. 19 and 20, 1901.

Frank H. Pritchard, M.D.

THE DEGREE OF DANGER FROM MILK OF TUBERCULOUS COWS.—Dr. Ostertag, examining the milk of one hundred cows which had reacted to tuberculin, found, from microscopic investigation, feeding and inoculation of guinea-pigs, that about half the number had tubercle-bacilli in their milk. Practically, milk from cows which react to tuberculin, but which do not present the clinical signs of tuberculosis, is harmless, and free from danger of infecting. Those cows with tuberculosis of the udder are the ones which are particularly dangerous to the community. Bacteriological examination and harpooning the udder, as recommended by Nocard, are of diagnostic value.—*Hospitalstidende*, No. 20, 1901.

Frank H. Pritchard, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

HOW TO PREVENT AND CURE SEASICKNESS.—Dr. A. B. Whitney, of New York City, after an experience covering some twenty years, is ready to vouch for the truth of the following: "Naval officers and private individuals, the strong and the weak alike, sickly and delicate, old and young, can be entirely exempt from the unpleasant and nauseating effects of seasickness by a judicious use of *Gelsemium*." His method, which he so strongly recommends, is to mix half a teaspoonful of *Gelsemium* tincture in half a goblet of water. A dose of one teaspoonful every quarter or half hour until the sickness has passed away. Take the remedy thus, and keep on deck.—*Eclectic Medical Gleaner*.

O. S. Haines, M.D.

CURE OF EPITHELIOMA BY KALI SULPH.—A woman, aged forty years, had for some years an open skin cancer upon the left side of her nose. Recently it had spread more rapidly, was painful, and had affected the eye. Size of cancer as large as a silver dime. Was given five grains of *Kali sulph.* 3x, three times daily, together with the local application of the same remedy in the 1x trituration. Result: A rapid and complete cure.—J. S. Leachman, M.D., in the *The Homœopathic News*. (There have been several similar experiences reported from time to time, so that the *Kali sulph.* should be borne in mind as a possible remedy for cases of epithelioma affecting a portion of the face in which operative procedures seem undesirable, or for cases who refuse operation. A woman, having a very small epithelioma upon the ala nasi, submitted to the application of a "cancer paste" in the hands of a quack. She suffered intolerable pain for weeks. When the paste was removed, after some five or six weeks, the epithelioma had gone; so had a portion of her nose. An unsightly hole through the nose was the result.)

O. S. Haines, M.D.

THE VALUE OF ODD SUBJECTIVE SYMPTOMS.—Dr. J. M. Selfridge was treating a severe case of pyelitis which had been so diagnosed by a skillful physician who had examined the case previously. It was thought necessary to extirpate the affected kidney. Although the patient was in bed, covered with warm blankets, she constantly complained to the doctor: "I feel as if the wind was blowing upon my limbs." This peculiar subjective sensation was regarded by Dr. Selfridge as a therapeutic keynote, so he prescribed *Hepar sulph.* It cured the pyelitis, and restored the patient to health.

This same believing homœopath had a case of puerperal metritis under his care. Symptoms: Stupid, quiet delirium; face hippocratic; tongue dry and brown; abdomen distended; lochia profuse, semi-fluid, putrid in odor; cold, clammy sweat over entire surface. Notwithstanding, the patient constantly

removed the bed covers, and insisted upon being uncovered. This latter peculiarity directed the physician's attention to *Secale*. The remedy cured the case.—*Pacific Coast Journal of Hom.* (Such peculiar, unusual and odd symptoms, when present in a case, do not necessarily indicate with positiveness a certain remedy. They are, however, most valuable aids to the careful prescriber, in that they *direct his attention* towards certain remedies, which should then be studied for the purpose of ascertaining whether said remedies have a homœopathic relationship to the case in toto.)

O. S. Haines, M.D.

TWENTIETH CENTURY CURE FOR "A COLD."—The suggestion of Dr. Nathan R. Simmons that *Avena sativa* will act with more certainty than any other remedy now in use for that condition popularly known as "a cold" is as startling as it is novel. The doctor, knowing with what certainty and promptness *Avena* restores a general warmth to the body, especially heat to the extremities; was led to do a little experimenting, and his results are quite interesting. Treatment should be begun as soon after the primary rigors as possible, and before the congested capillaries, whose walls may have been weakened by many similar attacks, have attained the inflammatory state. Given at this time, the *Avena* has seldom disappointed the author during the past four years. It being non-toxic, enough should be given to produce a slight warmth of the skin within ten minutes. Twenty to thirty drops is the usual dose, which may be repeated in from two to three hours, until the patient feels sure that his cold has been broken up. When used as above advised, in a case of cold affecting the nose or throat, you will not have the usual history of muco-purulent discharge for two or three weeks. Its use is not followed by any undue moisture of the skin, and usually one or two doses will be sufficient. (Attention might be called to the fact that *Avena* occasionally produces severe headache, in the doses which the author has recommended). Let us reflect a moment on the intimate relationship existing between the vascular system and the vaso-motor nerves; also the extent to which the vaso-motors are controlled by the great sympathetic system, and, again, the quick response of the sympathetic to irritation of sensitive fibers of the cerebro-spinal system or nerves. If we follow this thought more at length we shall see how the mucous capillary system may be engorged by continued exposure of the extremities of the body to cold or to dampness. If the neck or shoulders, slightly moist from perspiration, be exposed to a draft of cold air, we shall have first local, then general contraction of the surface capillaries through the action of the vaso-motors. This is the first step of an approaching "cold," and if you expect to cure it in its incipency, begin where it did, on the nervous system, and restore an equal blood pressure throughout the surface of the body. Active exercise or a hot bath is sometimes efficient, but all agents that produce a relaxed, perspiring skin, should be used with great discretion. If we wish promptly to relieve the engorged mucous membranes, we must unlock the vaso-motor spasm. Blood will then flow freely to the surface, the skin will resume its functions of elimination, and the mucous membranes will be relieved in a measure from eliminating the poisons ordinarily thrown off through the skin. *Avena sativa* answers admirably in such an emergency.—*The Homœopathic Eye, Ear and Throat Journal*, June, 1901.

O. S. Haines, M.D.

SECONDARY ACTIONS OF CERTAIN NEW DRUGS AS OBSERVED BY DR. OTTO SEIFERT (Martzbouurg, 1900), and reported in German medical papers by Dr. Stager, of Berne.

Antifibrin.—Even in small doses, may produce anorexia, nausea, restlessness, chilliness, hardness of hearing, cyanosis, irregular or weak heart, dyspnœa.

Antipyrin.—Nausea, vomiting, burning of the stomach, sweat, coldness, weakness, insomnia with anorexia, palpitations, chilliness, pain in the chest and in the abdomen, ischuria, noise in the ears, dyspnœa, headache frequent, nervous excitement, senses blunt, delirium, transient absent-mindedness, loss of memory, urticaria, erythema rubeoliform or scarlatiniform, herpetiform, exudative, ulcero-membranous stomatitis, redness and swelling of the lips, œdema of the face, vesicular swelling of the mucous membrane of the pharynx, eruptions of a syphilitic appearance at the anus and at the genital organs.

Salipyrin.—Headache, pyrosis, vomiting, exanthema.

Citrophen.—Sweat and weakness, headache, ringing in the ears, cyanosis.

Ecalgin.—Vertigo, intoxicated feeling, sparks before the eyes, tinnitus aurium, sweats, myosis, albuminuria.

Lactophenin.—Nausea, vomiting, noise in the ears, vertigo, sweats, paræsthesia of the upper limbs, cyanosis, collapse, icterus, meteorism, intestinal hæmorrhage, delirium, arrhythmia of the pulse, macular exanthema.

Salophen.—Profuse sweat with weakness, vertigo, noise in the ears (pulse slow).

Cannabium purum.—Heaviness and sleepiness of the limbs; weakness; contractures; vertigo; difficulty of speech, hallucinations, anxiety, palpitations, pulse irregular.

Chloral.—Nausea, vomiting, vertigo, head not clear; nephritis, fatigue.

Chlorhydr. of Cocaine.—Paleness, sudden vertigo, formication and coldness of the limbs, cold sweats, pulse small and frequent, respiration shallow, mydriasis, pericordial anxiety, nausea, vomiting, headache, trembling, unsteady gait, weakness of reflexes, noise in the ears, transient unconsciousness followed by weakness. Sometimes fancy ideas verging to delirium, with hallucinations.

In graver cases, prolonged weakness, or chorea with contractions clonic and tonic, mental disturbances, difficulty of speech, dyspnœa, cyanosis, collapse and death. In chronic cocaineism: emaciation, diminished nutrition, color pale, insomnia, abnormal sensation on the skin, weakness of the memory, loquacity, state of irritation, demoralization.

Hyoscine hydrobromate.—Dryness of the throat, visual and cardiac disturbances.

Methyl blue.—Nausea, vomiting, tenesmus vesicæ, urine of a blue or dark-green color, weakness of the heart owing to muscular degeneration.

Migrainin.—Burning in the mouth and of the throat, redness and swelling of the lips, of the buccal cavity of the throat, pain and tears in the eyes, sialorrhœa; burning in the bladder and urethra, sensation of chilliness and heat, dyspnœa, pulse accelerated, irregular, trembling, cerebral irritation, nystagmus, cyanosis, scarlatiniform exanthema.

Orthoform.—General erythema, nausea, vomiting, necrosis deep of the tissues.

Paraldehyde.—Dryness of the pharynx, burning thirst, headache, vertigo, weakness in the legs, slight delirium.

Sulfonal.—Anorexia, vomiting, noise in the ears, vertigo, legs unsteady, apathy, insomnia, irregularity, slowness of the pulse, cardiac palpitation, hallucinations, hesitating speech, hyperæsthesia of the senses; slowness of the expression; aphasia, delirium, coma, cyanosis, toxic nephritis. When the drug has been used a long time, nausea, vomiting, gastralgia, diarrhœa, vertigo, cephalalgia, dullness of the senses, illusions, somnolence, diffuse and generalized pains, paresis, unsteady gait, ataxia, paresthesia, decrease of cutaneous and tendon reflexes, temperature high, constipation, colic, oliguria, ischuria, incontinence, intense thirst and dryness of mouth, neuritis of the toes, extending to the lower extremities and to the trunk, causing sensory and motor paralysis, scarlatiniform eruption, purpura or brown spots on the face.

Trional.—Weakness of the limbs, anorexia, nausea, vomiting, headache, vertigo, diarrhœa, noise in the ears, anxiety, palpitation, irritating state, ataxia, mania, uribilinuria. By long-continued use of the remedy, headache, vertigo, anorexia, colic, weakness, depression of spirit, sometimes irritation, delirium, arms and legs moving hesitatingly, speech disturbed, cramps.

Bromoform.—Used by allopaths in whooping-cough. Mind disturbed, vertigo, head falls over the chest, face pale, lips purple, muscles soft, weakness in the arms and legs, while the masseters remain contracted. Skin of the body is cold. reflexes and sensibility to pain are diminished, respiration frequent, superficial, stops at times, bronchial and tracheal breathing, heart-beat weak and accelerated.

Naphtholin.—Anorexia, vomiting, thirst, headache, urinary tenesmus, black coloration of the urine, unsteady gait, state of irritation, cyanosis, respiration quick, pulse accelerated, albuminuria.

Orexin.—Burning sensation of the buccal and pharyngeal mucous membrane, attacks of vertigo and noise in the ears, vomiting.

Salol.—Eczema erythematosa, nausea, sensation of weight, of fulness, noise in the ears, attacks of heat, vomiting, depression, gastric troubles, eczema of the lips.

Diuretin.—Anorexia, nausea, vomiting, headache, somnolence, palpitation, dyspnœa, collapse.

Uricedin.—Intense pyrosis, thirst, pressure, headache, weakness, diarrhœa.

Acid cacodylic.—Erythrodermy generalized with consecutive desquamation.

Airol.—Œdema of the penis, vesicular eruption, dermatitis of the forearm.

Iodothyryn.—Cephalalgia, vertigo, vomiting, intellect diminished, weakness, arrhythmia of the pulse, decrease in the weight of the body, erythema.

Naphthol B.—Vomiting, cephalalgia, somnolence, hallucinations, maniacal attacks, pulse quick, albuminuria, fever.

Remedies for tuberculosis and the symptoms which follow :

Acid camphoric.—Gastric irritation, exanthema of the skin.

Acid cinnamyllic.—Headache, rheumatic pains in the thorax, weakness, congestion in the head, vertigo, nervousness.

Agaricine.—Diarrhœa, slight acceleration of the pulse.

Duboisine.—Thirst, yawning, mydriasis, visual disturbances, sparks before the eyes, apathy, mental paralysis, vertigo, trembling, sweat, breathing shallow, pulse quick, contracture of muscles.

Kreosote.—Anorexia; eructations, gastro-enteritis, difficulty to swallow, gastralgia, vomiting, diarrhœa, weakness, paresis, vertigo verging to delirium, cramps of the extremities alternating with a paralytic weakness, involuntary micturition.—*Allg. Homo. Zeitung*, No. 11, March, 1901.

John Arschagouni, M.D.

KALI PERMANGANATE FOR SPASMODIC CROUP.—Well, here's another "specific" use for permanganate of potash. We have often wondered why we always carry the pretty crystals in our buggy case, and now we know. It is a specific remedy for the croup paroxysm, which is the nocturnal bugaboo of many a happy household. Dr. B. H. Sleght, of Newark, says it is, and one will be safer in trying this suggestion before condemning the remedy; for Dr. Sleght is not a man given to making statements that he cannot substantiate. The doctor has had six years' experience with the remedy in croup, and administers it to the child by dissolving just enough to give a cherry-red color to a glass of water—one-eighth of a grain is enough for this. Dose: One teaspoonful every five or ten minutes. He uses it also in laryngismus stridulus, and in diphtheria involving the windpipe. It brings speedy, complete and gentle relief to the *croup paroxysms*. Before the fifth dose the crowing has usually ceased, the child sleeps, there is no vomiting, no two-hour sessions with the lime salts, or with Spongia or Kali bich., with a sleepy doctor on one side of the crib and an anxious mother on the other. But, after the croup paroxysm has been subdued, and tranquillity once more reigns, we must prescribe whichever remedy is indicated for the laryngitis, or other conditions which may have determined the attack. The 2x or 3x triturations have not proven to be as certain as the fresh solution prepared as above.—*Hom. Eye, Ear and Throat Journal*. (This may be an excellent remedy for the parents of croupy children to keep on hand, and may save the busy doctor from some hurry-up calls, after midnight.)

O. S. Haines, M.D.

CACTUS AND DIGITALIS COMPARED.—We sometimes think that our Eclectic brethren have a very happy way of presenting an outline of the therapeutic range of drugs. Thus quite recently a writer in the *Eclectic Journal*, in comparing the two drugs, Cactus and Digitalis, in heart affections, said: "Cactus is a remedy, we believe, chiefly for *functional* heart affections, exerting its effects chiefly by its control over the nervous mechanism of the heart; chiefly, if not wholly, through the sympathetic. However, we believe that its long-continued use benefits the heart tissues, for it appears to increase the nutrition and waste of the heart-muscle. It is conceded to be of great value in mitral *regurgitation* due to valvular insufficiency. Now, if *structural* heart disorders be aggravated by disordered innervation, whether the heart's action be feeble, rapid, violent or irregular—if there is mental depression or mental excitation—this remedy gives relief as promptly as any agent known. In the band-like constrictive cardiac pain, in spasm of the heart-muscle, nervous palpitation or cardiac neuralgias, it may be our best remedy. The following *indications* have been well verified: Impaired cardiac movements, whether feeble, irregular or violent. Heart disorders with marked nervousness or apprehension of death, anxiety, precordial oppression or constriction; and the irritability arising from a tobacco heart." All this is very interesting and well expressed. Now let us see what of *Digitalis* from the same Eclectic standpoint.

Digitalis is a decided heart sedative and tonic, and is adapted to both functional and organic troubles. It lacks, in a measure, the nervous indications so strongly exhibited when *Cactus* is called for. It is the remedy for *asthenia*, and is contra-indicated by high arterial tension and powerful heart contractions. Weak, irregular heart-beat and low arterial tension are its direct indications. It is called for in cardiac dilatation, with feeble and irregular pulse. When the *aortic* valves are faulty, and permit regurgitation, it may prevent valvular leakage, because the heart is relatively weak, and stronger contraction is needed to propel the blood onward.

The *indications* for *Digitalis* are: Weak heart-sounds; weak, rapid, irregular pulse, with low arterial tension; jugular pulsation, with dusky or cyanotic countenance; dyspnœa; cough; scanty urination, with œdema or anasarca.

The troubles in which *Digitalis* is a positive remedy are: Positive or relative heart-muscle debility; dilated right heart with tricuspid incompetence; dilated heart with mitral incompetence.—*Eclectic Medical Journal*, July, 1901.

O. S. Haines, M.D.

CALCAREA CARBONICA.—Frank Kraft, droll, epigrammatic and audacious, has pictured the *Calcarea patient* in *The Medical Century* for July, and we like his vivid portrait, yet cannot understand why he should say, "I have tried for some time to picture to myself a grown-up man to be a *Calcarea* carbonica patient. But I have failed." We cannot believe that it is mainly women and children who fall within the special scope and influence of this remedy. How about the "rheumatisms" and "gastric disorders" in men, which we so often find indicate *Calcarea*, and not *Rhus* "nor *Nux*" nor *Puls*. after all. Dr. Kraft says: "The *Calcarea carb.* patient is a chronic sufferer; he is one of that unfortunate class who are endowed with a heritage of sin and corruption. There are but few of the most commonly known ailments dipping into heredity, like consumption, cancer, scrofula, and the like, that do not, at some point along the line of degeneracy, find their similar in *Calcarea*. As children, they are cold and clammy; illy nourished, usually bottle babies, and most frequently condensed-milk bottle babies. They are *slow* in everything; slow in teething, in walking, in talking. They may be mamma's big, bouncing, fat and chubby girl, weighing thus and ever so much, but the blight of lime-less-ness is over it all. Although fat and fluffy and unwieldy, it lacks life; its cheeks are never red; its eyes are dull and fishy, and often sore; it is prone to snuffles, to sore ears, to bowel troubles; in short, to all the effects of malnutrition. It is a poor feeder; that is, it eats ravenously at times, but its stomach lacks assimilative power. The little or the large abdomen is turned up like the bottom of a saucer, and filled with gases. It is not a crying baby, but rather a peevish, fretful child. When its teeth do come, they early show signs of decay and deformity. There is much sweat about the head and feet. This child has large eyes, large nose, large ears, large hands and feet, large fingers and large joints. Its skin is the color of pie crust. It is the direct opposite of the *Phosphorus* child, which is fine and refined, delicate, and as smooth as silk. The grown-up woman *Calcarea* patient has that cellary, dank, damp basement-like odor about the hair that is very noticeable."

In connection with this resume of the *Calcarea* patient, the author narrates a most interesting case of a scrofulous child, which rather tends to prove how much homœopathy can sometimes do towards removing the handicap placed by heredity upon these infantile wrecks.

O. S. Haines, M.D.

PREVENTION BETTER THAN CURE.—In a recent Homœopathic Society discussion, a physician, whose name we shall omit because we are not criticizing an individual at the present time, reported an interesting and serious case as follows: "In January of this year I delivered a child at nearly full term that showed the evidences of having been dead for a considerable time. The mother had been well up to the time of delivery. The placenta was adherent. I had to remove it. It did not come very readily. In fact, after trying for twenty-four hours, I found it impossible. I could get only small pieces, and only by force. I therefore relied upon the remedy rather than upon surgery, and around the fifth day, the discharge having become very offensive, there came on the characteristic symptoms of sepsis, chill, rapid pulse and low temperature, and also the feeling of soreness all over the body, so that the bed seemed very hard. Now," continues this intrepid observer, "all these symptoms being found under *Pyrogen*, I gave the woman one dose of the C. M. potency, and in a very short time there was a marked improvement. This single dose was enough to bring on a satisfactory convalescence. The patient came down to the dining-room in a few days, and was able in five weeks to take a sleigh-ride." This simple tale reminds us of another story: "One winter night, several workmen in one of the large quarries of our State were discussing the peculiarities of dynamite cartridges. One man expressed himself freely, and said that in his opinion all this talk about the dangers of thawing out frozen cartridges in one's oven was the veriest nonsense. He thought the long set of rules, based upon the experiences of years, which the company insisted upon their employees following, were unnecessary and ridiculous. He then told how he had quite recently left some dynamite cartridges in the oven of his kitchen stove, and had forgotten all about them until after breakfast the next day. Nothing happened. An Irishman, lately arrived at the quarry, listened to the narrative, and was much impressed thereby. Some weeks afterward his dynamite froze; he placed it in the oven of his stove, and sat down to smoke his evening pipe.—His corpse was found a long ways off, wearing one sock and an incredulous smile." The moral is the same in each of these stories. If you doubt this, let some one of us try the methods recommended by the aforesaid intrepid observer, and then we shall be convinced.

O. S. Haines, M.D.

ECHINACEA ANGUSTIFOLIA IN THE TREATMENT OF APPENDICITIS.—Much has been written and published, during the past three years, relative to the therapeutic properties of this drug, some of which has been subsequently found to be partially true. In the July number of *The American Homœopathist*, Dr. J. Arthur Bullard, of Wilkes-Barre, Penna., says positively and convincingly that he has found *Echinacea* to be a very dependable remedy in true *appendicitis*. In septic peritonitis, also, it has acted more brilliantly than any other drug that he has used. This author seems to prefer the 1x potency, although he has used the tincture and the 3x dilution as well. He urges all those who may be unfamiliar with this use of the drug to try it. Dr. Bullard offers us as the keynote for the remedy "*Bad Blood*." (*Echinacea* has undoubtedly some power over septic conditions. Boils, carbuncles, septic inflammations of the pelvic viscera and malignant diphtheria are among the diseases which it is said to have cured. Those who desire to read the proving of this remedy may find it in *The Hom. News* for June, 1901.)

O. S. Haines, M.D.

OUR SHORTCOMINGS.—The first article that catches the eye, upon the bright and attractive pages of the *Medical Century* for July, is from the pen, and heart, too, of George Royal, of Des Moines. One may quickly sense the truth contained in this "talk," which the doctor originally delivered before the Hahn. Med. Assoc. of Iowa. He says much has been written and said about the imperfections of our materia medica, but the more closely he observes the results obtained from the remedies, as well as the practice of many physicians, the more he is convinced that the imperfections of the materia medica are as motes to beams, when compared to the shortcomings of physicians. He does not think "the numerical totality" is the real totality in more than three cases out of ten, because the true homœopathist must know what organs and tissues a remedy will affect, and what changes it will produce, in order to thoroughly and scientifically estimate the comparative value of different symptoms. When he says that he does not believe that one-half of our students carry out in their practices the instructions they receive in college, he probably comes nearer to the truth than those who clamor that students are badly taught. He cannot tolerate the practice of alternation, because the only way in which the physician can know what a remedy will do in an individual case is to give that remedy by itself. He speaks very strongly against the use of the "combination tablets." Several old school authorities have lately stated that the therapeutics of their school are being dominated by the druggists; that most of the prescribing at the present time is being done at the solicitation and practically under the direction of their "leading pharmacists." Dr. Royal fears that our school is not so very far behind.

O. S. Haines, M.D.

GERANIUM IN THE TREATMENT OF DYSENTERY.—In *The Homœopathic World* for July may be found an interesting communication from a surgeon "at the front" in South Africa. In this letter he speaks of his success with *Geranium* in the treatment of the dysentery so prevalent among the English forces now in that region. It appears that there is quite a difference in clinical features between this dysentery and the variety commonly known as "tropical dysentery." Thus the writer has noticed the absence of very severe tenesmus. Neither are the stools so frequent nor so scanty as in tropical dysentery. Vomiting is exceptional. The temperature of the patients was more frequently *subnormal* than high. On the other hand, he observed that the copious stools were passed with extraordinary *suddenness*, and were often involuntary. Complications were rarely present. Abscess of the liver, to his knowledge, never occurred. The hæmorrhages seemed to be due to a general oozing from the intestinal mucous membranes. Considerable mucus of the consistence and appearance of arrowroot might be seen resting upon the top of the motions. This observer used in all his cases the *common red geranium* of the garden, the root being cleaned, cut into strips and boiled. In the earlier stages of the disease, from 5 to 10 minims, three times daily, were quite enough. At no time was it necessary to raise the dose to more than 30 minims. Notwithstanding that the disease had proved fatal in several cases before the use of the *Geranium*, but one case died afterward. This case, unfortunately, developed appendicitis as he was recovering from the dysentery, was successfully operated, but subsequently died from obstruction, due to the formation of cicatricial bands in the wall of the gut.

O. S. Haines, M.D.

THE HAHNEMANNIAN MONTHLY.

SEPTEMBER, 1901.

IS DIAGNOSIS A PREREQUISITE TO TREATMENT?

BY JOHN PRESTON SUTHERLAND, M.D., BOSTON, MASS.

THERE are few subjects on which there is not room for an honest difference of opinion; few questions which, on impartial examination, do not present two sides. That is why I have chosen as the title to my paper a question, and not a dogmatic assertion. As I hope you will discover, if you have the patience to follow me to my conclusion, I have, in my own mind, very definitely answered this question; but that has not prevented my finding much interest in arguments that seek to prove the contrary of the conclusion at which I have arrived, and I see no reason why it should prevent me from submitting such arguments to you, in all good faith, side by side with the arguments which support my own conclusions.

Homœopathists have often been accused of indifference to pathology and all things connected therewith; they have been qualified as simply "symptom-coverers" in their prescribing. The charge has been laid at their door that they neglect the detail of training in physical examination, which is indispensable to the skilled diagnostician. A cursory inspection of the curricula of our medical schools is sufficient to show that so far, certainly, as the present era is concerned, such charges are easy of refutation. The pioneers, to whose courage, skill and success the introduction of the homœopathic principle to popular faith and favor is to be credited, were fully trained, before

their conversion to homœopathy, in all that the schools, their teachers or their colleagues had to impart. If, for a time, they and their immediate successors devoted themselves to the great task of constructing, *de novo*, a materia medica, to the exclusion of most other lines of study and accomplishment, who that realizes the magnitude of that task can grudge their making it an all-absorbing one? Let others add to the resources of pathological knowledge, to the building up of diagnostic skill; it was the work of these, our pioneers, to learn how to cure disease, and to teach others how to cure it. To each his work. The work of these men follows them, now that they rest from their labors.

Do we find in them an example that should encourage us, who possess the materia medica it was their special function to create for us, to stint or refuse attention to the study of pathology and diagnosis, because they lacked time to pursue such study, being absorbed in their special and mighty task? It is because there are some physicians, even to-day, who answer this question partly or altogether in the affirmative, that I ask you to examine with me certain of the arguments by which such physicians support their position.

The importance of a correct diagnosis is realized by more physicians than realized it even a quarter of a century ago. Yet there are to-day, as I have suggested, physicians who—some tacitly, some by openly avowed theory—regard pathology as a greatly over-estimated science. In support of this position, it is said, among other things, that for the physician to be absolutely dependent on a diagnosis that he, at least, is satisfied is the correct one, before he can enter on the treatment of a patient with any degree of confidence, is sometimes a serious handicap to his practical usefulness. We all know that there are cases whose pathological nature is never settled till the sick-chamber is become the death-chamber. Well says Musser,* “Notwithstanding our efforts to collect data by inquiry and by observation, we are often unable to make a diagnosis. This arises when premises are wanting for the process of induction. The subjective symptoms may not tally with the known processes

* “A Practical Treatise on Medical Diagnosis.” By John H. Musser, M.D. Phila. : Lea Bros. & Co.

of disease, or the narrator of the history of the present disease may omit important evidence from lack of memory or knowledge, from design, or from other reasons. The objective phenomena may be developed in an ill-defined way, or they may be obscure, as the state of the abdominal contents in a person who is obese, or they may point to one or more processes, the subjective symptoms of which are not present. At the time of observation the disease may not have developed fully, may not have 'spelled itself out.' Under these circumstances a provisional diagnosis must be made, or conclusions held in abeyance." In such cases, however, treatment cannot be "held in abeyance." Something must be done; and something can be done. The physician must early recognize the existence of these non-diagnosable cases, and not be appalled when he encounters them. It may tend to minimize the absolute necessity of diagnosis in his eyes, yet increase his confidence, and thus his practical efficiency, to know that these obscure and unclassifiable conditions are by no means always fatal conditions; that a patient may make a good and permanent recovery, and sing aloud the praises of his physician, as a good patient should, after suffering for weeks or months from a malady of whose nature his be-praised physician has had, throughout, no more idea than the trustful patient himself. Experiences of this kind may tend to weaken a practitioner's absolute respect for diagnosis; and we must estimate this argument at its full worth when weighing the question that now occupies us. Again, should the unrecognized case prove fatal, as in a case of acute hæmorrhagic pancreatitis which very recently was treated at the Mass. Homœopathic Hospital, in which exploratory incision failed to reveal the real nature of the then not fully developed disease, the physician may comfort himself with the certainty that, had he known never so well the sad state of things that the post-mortem revealed, he could have done no whit more to save his patient than he did in ignorance of it. There is comfort in this thought, in the cases where an accurate diagnosis has proven impossible. Whether there is anything in this thought to weaken faith in the necessity of diagnosis in cases where it is obtainable, I leave you to determine. There are some who would decide this question in the affirmative.

Before we leave this aspect of our argument we must dwell for a moment on the fact that, in the absence of a diagnosis, the homœopathic practitioner is not without reasonably reliable resources. Symptoms are existent, and readable, and classifiable, where diagnosis is blind. Our prescribing, in the vast majority of our cases, is based on the totality of symptoms exhibited by our patients. Therefore we may prescribe with a very tolerable amount of confidence in cases where others equally at sea as to a diagnosis would be in a much more difficult position. Is there ground here for the claim advanced, even to-day, by many of our brethren, that much of the time spent in determining a diagnosis is wasted time? I leave that for you, again, to determine. There are many who would decide this question in the affirmative.

Yet another argument on the side we are now contemplating lies in the fact that an incorrect diagnosis may often lead to mistaken and even dangerous treatment.

It is within my knowledge to have a case of ovarian cyst mistaken for an ascites, paracentesis abdominis being repeatedly performed on the strength of the diagnosis. Subsequently a diagnosis of ovarian cyst led to a cœliotomy, the removal of the cyst being made somewhat more hazardous by the adhesions resulting from the preceding frequentappings.

I have known a tubercular meningitis, developing in an unusually acute manner and without some of the customary symptoms, to be incorrectly diagnosed and treated as a case of typhoid fever. In cases of this class, the danger connected with the employment of the law of similars is as nothing to the dangers following the use of empirical methods. Are the dangers incident to a mistaken diagnosis, and the treatment resultant on this mistake, a weighty argument against seeking and relying on a correct diagnosis? I leave this to be answered by yourselves; but there are many who in good faith employ this argument against devoting too much time and thought to the making of a diagnosis.

Yet one more argument against laying stress on the importance of a diagnosis, and we may fairly consider the case on that side as closed. A real and grave danger to a patient from a mistake in diagnosis occurs when the diagnosis made is a graver one than the facts warrant. The disheartening of pa-

tient, family and physician by a gloomy diagnosis, and its inevitable prognosis, may not infrequently result in bringing about the truth of the prognosis in the death of the patient, when nature, left unchilled and unhampered by gloomy foreboding, might have wrought a cure. Even in the cases where the gloomy prognosis is the true one, life may sometimes be prolonged, by the patient and the family—it may be even the physician himself—being buoyed up by the hope of a happier outcome. Illustrations are not far to seek. We all know the terror that strikes to the heart of a patient when he hears what he takes to be his death-sentence in the diagnosis of “consumption,” “Bright’s disease,” “cancer,” and other names of dread; we all know the discouragement that overtakes the physician when some incurable condition stares him in the face. Is there reason in this fact for leaving the diagnosis unmade? Decide that for yourselves.

I should, perhaps, before passing altogether from this side of the argument, mention the circumstances—too often existent—under which a diagnosis is frankly superfluous. I refer to the treatment of diseases of all sorts by the proprietary preparations with which the pharmaceutical market is flooded. Time was when these preparations were advertised to the laity alone; when the methods of the advertisements ran to the exhibition of the newspaper portrait of the mayor of West Appleslump Corners, with his enthusiastic testimonial to the cure wrought in him thereby. To-day the advertising is boldly and iterantly addressed to the profession, and garnished with medical terms frequently more or less weirdly misapplied; but the article offered is in most instances the same old cure-all, and its use renders diagnosis as superfluous to the physician as it used to render it to the laity. Instance the advertising circular of one of the new preparations that lies before me as I write—a circular issued, alas! by a well-known and reputable pharmaceutical house—which circular sets forth the virtues of a formula “secured from a gynæcologist abroad, whose success and experience have been simply phenomenal in this line;” and warranted to cure not only a notable list of “rhœas” and “itises,” but also adding a naïve request that, “the sphere of this remedy being so wide and varied, we ask the profession to prescribe it also in conditions not mentioned in this report.”

The physician whose practice is moulded by, and who prescribes in accordance with circulars and recommendations such as this,—and that there are, unfortunately, many such, is testified to by the waxing wealth of the manufacturers of these preparations!—definitely does away with the question as to the need of diagnosis.

We now may turn—I confess not reluctantly, on my part—to the other side of the question of the necessity of a diagnosis as a prerequisite to treatment. And here it is scarcely too much to say that the first reason that inevitably confronts us why diagnosis is so inescapably a necessity is sufficient, taken by itself alone, to establish the affirmative side of our question. I refer to the danger to the community from a neglected or too-long-delayed recognition of the existence in its midst of a contagious disease.

I need not dwell on how many diseases present to the prescriber symptoms deceptively resembling each other which, pathologically, differ by a dangerous world's-width. Follicular tonsillitis and diphtheria; slight jaundice and pernicious anæmia; intestinal colic and appendicitis; scrofulous glands and Hodgkin's disease; maladies of innocent seeming, and those which are syphilitic in origin and death-dealing in effect—these need no introduction to your notice, nor argument to prove to you the fatal result of delaying their accurate diagnosis. If the testimony these offer on the affirmative side of our question be not enough, let me suggest to you a final argument: that diagnosis as a prerequisite to treatment does not mean, alone, diagnosis as a prerequisite to the administration of drugs, but as a prerequisite to treatment as a broad and comprehensive whole—treatment dietetic, climatic, hygienic, adjuvant; and without diagnosis as a guide to the character of such treatment we are doing our patients a gross and shameful wrong. An ounce of example is worth a pound of precept. Let me offer you, as briefly as possible, a few examples that illustrate this most vital point.

For instance, I have known a case of diphtheria to be mistakenly diagnosed as follicular tonsillitis, the true nature of the disease not being recognized until two nurses and four members of the family contracted the disease, three fatal cases resulting. This sort of thing is not as infrequent as it should be.

It has four or five times been my experience to have a patient apply for treatment for "malarial fever," of the diurnal intermittent type, so diagnosed and accordingly treated, on account of the periodical chills, fever, and sweats, with more or less prostration. The patients complained of no other symptoms; but careful examination revealed the presence of objective signs of pulmonary tuberculosis, which eventually proved fatal.

Mrs. K., age 65, six or seven days ill with rheumatic fever; temperature 101° to 102.5° ; profuse sweating. All the large joints, one by one, became affected. Temperature on the sixth day of treatment 101° ; all pain had disappeared; when, during the night of the sixth day or morning of the seventh, a temperature of 105° developed. The diagnosis hyperpyrexia was easily made; but why should hyperpyrexia occur? Then was done what should have been done before: the urine was examined, showing a specific gravity of 1003. The patient's temperature was reduced to 102.2° on the eighth day of treatment, but went up to 105° on the evening of the same day, and on the morning of the ninth day the patient died. A second examination of the urine had shown a specific gravity of 1007, and a small twenty-four hours' excretion. Here we had a case of marked renal insufficiency, due, probably, to interstitial nephritis, resulting in injurious retention of the waste products. The hyperpyrexia was the result of an auto-toxæmia.

This case, though treated closely by similars and with the aid of a consultant, was not correctly diagnosed in the early stages of the disease. The essential feature of the case was not the rheumatism, but the pre-existing nephritis. Had this been recognized prior to the attack of rheumatism, the outcome might have been different.

Mr. J., æt. 30, commercial traveller, treated for gastritis in various parts of our country; lavage was finally resorted to, but the washing did no good; when I saw him he presented no evidence of catarrhal gastritis; no dilatation, no ulceration, no pyloric stenosis, no cancer; his chief complaint was a distressing flatulent dyspepsia; examination included urinary analysis; result showed excretion of about a pint in twenty-four hours; specific gravity 1023; but even so, there was a

marked insufficiency for one of his size and activity. Recognizing this as an important symptom, and considering it a causative factor in his case, an attempt was made, by flushing his system, to remove it. This, fortunately, resulted in a cure.

We all have had experience in treating headaches. Not infrequently, after a long period of treatment, the patient makes a report of palliation only; remedies may have been carefully selected, but the cure has not followed. The headache may be due to eye-strain or defect, and recognition of this fact is the first step toward instituting a curative treatment.

S. M., 6 or 7 years of age, had been treated some months for croup and loss of voice, having had croupy paroxysms, much cough, and a voice which passed through all gradations of hoarseness to aphonia. Laryngoscopic examination, which during the months referred to had not been made, showed the presence of a small papilloma on the right vocal band. Naturally the case was outside the range of medicine, but removal of the tumor resulted in gradual restoration of the voice.

Only a few months ago a little girl, aged 11, came under my observation. For eight months she had been under treatment for enuresis, but as no marked improvement was visible, she was sent for examination. She was a large and strong girl for her age, and had been in excellent health until the early summer of 1900, when her infirmity first appeared. The enuresis became diurnal and nocturnal. Examination of the urine in this case showed a well-developed pyelitis, and further investigations, bacteriological in nature, established beyond the possibility of a doubt the diagnosis tubercular pyelitis. The few symptoms which were sufficient for the diagnosis, enuresis, were not sufficient for a comprehensive and possibly curative treatment. In this case the treatment must be assuredly more than the mere administration of drugs; it must be dietetic and hygienic, and include in its scope everything that tends to the upbuilding of strength.

In conclusion, what question fitter to ask ourselves than this: What is the true position of Hahnemannian homœopathy in its relation to pathology and diagnosis? It is surely an apposite inquiry, as we conclude the discussion of the opinions of others, and as we seek to finally formulate an opinion of our own. We are not left to guess the attitude of the founder of

homœopathy on this matter. Hear him. I quote from the first and third paragraphs of the *Organon*: "The physician's highest and only calling is to restore health to the sick, which is called healing. . . . The physician should distinctly understand the following conditions: What is curable in diseases in general, and in each individual case in particular; that is, the recognition of disease. He should clearly comprehend what is curative in drugs in general, and in each drug in particular; that is, he should possess a perfect knowledge of medicinal powers. He should be governed by distinct reasons, in order to insure recovery, by adapting what is curative in medicine to what he has recognized as undoubtedly morbid in a patient.

. . . Finally, when the physician knows in each case the obstacles in the way of recovery, and how to remove them, he is prepared to act thoroughly and to the purpose, as a true master of the art of healing." I do not know a worthier or a finer conception of the duty of the physician. I do not believe there exists a more succinct, a more exhaustive, a more logical, a more rational, a more perennially satisfying statement of the relationship and interdependence of pathology and diagnosis, and of their joint relationship to therapeutics, than is contained in these brief quotations from the *Organon*. Those physicians who decry patient study to establish an exact diagnosis before treatment is entered upon have no progenitor in the wise and great master of our craft; they have no warrant for their theories of the uselessness of such study, either in the writings or in the practices of Samuel Hahnemann. In his infinitely patient researches into the causes of disease, he set us an example our utmost patience of labor cannot overmatch. In his dicta, above quoted, he gives perpetual contradiction to him who seeks either to brand or to laud Samuel Hahnemann as the father of mere symptom-covering prescribers. "The totality of symptoms"—this is an old shibboleth of our School. Rightly viewed, it is better than a shibboleth—it is a motto for a battle-flag. What is the totality of the symptoms? Is it anything less than the grasp of all recognizable subjective and objective signs of disease, and of the causes, natural and artificial, which have combined to produce a given morbid condition? If we rest content in a less comprehensive, a less strenuous interpretation of the phrase, we do so without the

warrant of Hahnemann. We have come into the inheritance of an almost innumerable greater number of aids to the precise determining of the nature of a given disease than were accessible in his day. In proportion as we use these aids intelligently, patiently, conscientiously, and give ourselves no ease this side of their mastery and the use of all the knowledge obtainable through their means, we work in the spirit in which Hahnemann worked; the spirit of true physicians; masters of the art of healing.

THE WANING OF FAITH IN DRUGS.

BY ELDRIDGE C. PRICE, M.D., BALTIMORE, MD.

(Read before the American Institute of Homœopathy, June, 1901.)

IN any line of work the best results are secured only through the systemization of the principles and facts upon which that work depends. Nothing has yet controverted the self-evident proposition that a straight line is the shortest distance between any two points. To reach a goal means the accomplishment of a purpose, and the accomplishment of a purpose means the establishment of a sequence of ideas, conditions or things which connect the start and the finish by the line of intent; and, to make our circle of thought complete, the more logical the sequential chain the straighter the line between the two points. To demonstrate this proposition of the straight line, however, it is essential that the exact location of both the starting-point and the finish be known; and, once known, there is usually the possibility of making an intelligent connection between the two given points.

In the present situation of doubt of drugs the foregoing principle aptly applies. The starting-point is in the accurate knowledge of what drugs will do, the goal is the resulting cure of the patient, and the links connecting the knowledge with the goal are constituted of a clear understanding of how to apply the knowledge to produce the cure. Given the knowledge and the method, the cure is more likely to result than if either the knowledge or the method of application be incorrect or in any way deficient.

It is safe to assume that physicians of to-day have less faith in the efficacy of drugs in the treatment of the sick than they possessed two or three decades ago. This means either that the knowledge of what drugs can do is not sufficiently accurate to satisfy the demands of the modern active practitioner, or that the methods of applying this knowledge are defective, or both; or it may further be considered whether or not drugs are really capable of producing the cures that have been claimed for them in the past.

The allegation that drugs have cured disease conditions is too well sustained by facts to need further investigation, and we are therefore left to the consideration of whether or not the cause of this modern defection be lack of correct systematized knowledge, or defective therapeutic methods, or, further, whether this lack of faith be confined to the indolent members of the profession and to undergraduates alone. We have only to read current medical literature to find that doubters are among the thinkers of the profession, and we are therefore forced to the conclusion that there must be some real and serious defect to account for the lack of faith of the practitioner and the timidity of the applicant for State license.

If we are to judge from the writings of Dr. William Osler of the Johns Hopkins University, the older school of medicine is even more tinctured with this therapeutic nihilism than is the homœopathic branch of the profession; but these remarks have to do solely with the avowed practitioners of homœopathy.

On scanning this field, several contributory reasons for this weakening faith become apparent, one of which is due to expecting too much of drugs. This over-sanguine expectation depends necessarily upon ignorance of just what we have a right to expect. As investigation has revealed more and more of the possibilities of metabolism and the impossibilities of certain changes in tissue metamorphosis and growth, so have physicians come to a knowledge of the improbability of drugs effecting changes which in the more ignorant past were not only believed possible but probable. Certain morbid growths and conditions might be instanced as usually impossible of removal by other than mechanical means, such growths and conditions in former times having been confused with other somewhat morbid changes that really are amenable to drug influ-

ence, and which confusion even yet sometimes reacts to the detriment of therapeutics. Surgery has certainly attained great prominence in recent years; by surgical means many conditions are remedied at once that in the past were treated more or less successfully by drugs. In some cases therapeutic failures have been succeeded by brilliant surgical successes; and under such circumstances it is but natural that, in proportion as faith in modern surgical methods is strengthened, so is faith in drug efficacy weakened. On the other hand, many cases of cures by drugs have been claimed by zealous therapists, but such cases have attracted far less attention than the flash of the surgeon's knife. The progress of surgery, therefore, may be credited as one of the contributory causes of modern weakening of faith in therapeutics.

"Of making many books there is no end." Especially does this apply to books of drugs; and such books as some of them are! Containing, as not a few of them do, many purely theoretical recommendations for the use of drugs, and which recommendations, when tried by the young therapist, fail utterly to fulfill their sponsor's promise, have more or less effect upon the confidence of the beginner. Book-making is a responsibility, and personal vanity is an ignoble incentive to writing a book.

The preparations of the drugs themselves have their influence also. A weak tincture, an impure tablet or an adulterated trituration are stumbling-blocks in the way of the young practitioner's success, and may feed his skeptical tendency. Combination tablets are intended to lighten the labor of the active practitioner by furnishing him with therapeutic short-cuts; but in many instances they are mere laboratory productions, recommended for entirely theoretical reasons, without foundation in experience or in accord with any established therapeutic principle, and are, therefore, but poor substitutes for the carefully selected drug. In therapeutics, as in all other lines of work, the best results are attained and the greatest successes scored only after thorough knowledge of the subject, which must come through hard study. It may be safely asserted, however, that there would be fewer combination tablets were our knowledge of physiological drug effects more accurate.

It is presumed that our colleges, at this late day, provide their

graduates with such knowledge of *materia medica* and therapeutics that no doubt of the healing powers of drugs will ever enter their minds; but things are not always as they seem. Even to-day there are in existence some accredited teachers who tell their students, and with straight faces, that *all* cures following drug administration—no matter what that drug may be, or what its dilution—are due to the law of similars, because, forsooth, cures result in no other way. These men also teach other things, some of which are not practical, and some not true: *e.g.*, that a hypodermic syringe is a good thing to leave at home; that such and such a case was carried through typhoid fever successfully by diluted drugs, when in point of fact a well-known coal-tar product in material doses was the chief drug used; that the “totality of symptoms” is a therapeutic necessity, when as a point of fact the teacher himself has never found such an impossibility, and knows it; and that the size of the dose makes no difference, if the drug be indicated. The many cures made by ferrum, calcium, magnesium, sodium, and the proximate principles of the body generally, are even now being taught as due to the law of similars, regardless of the amount in which these agents are given, and the nutritive needs of the organism for these very substances. The great law of hygiene, the law of demand and supply, the law of dissimilars, of contraries, is ignored, and the plastic mind of the student moulded into deformity. Such teachers are really found alive in our colleges to-day, and are known by their faculties to teach such nonsensical and unreliable rubbish, and yet are allowed to promulgate such views. The inevitable result of such teachings is, in many instances, that the pupil, after futile attempts to demonstrate the truth of his collegiate instruction, ends by becoming a shining example of therapeutic pessimism. Is this remarkable?

A careful examination of usually accepted symptomatology text-books inevitably brings to our attention the admixture of alleged effects of all-sized doses of drugs, from massive doses of crude substance to high “potencies;” and, in addition, we also find an unclassified tangle of primary and secondary effects; all of which is certainly not qualified to give the student of drugs a very clear idea of the location and nature of his starting-point in the therapeutic race. As to any objection being

raised that the question of primary and secondary drug effects is too obscure to furnish material for intelligent discourse, we have but to meet the point by granting the objection as another reason for a lack of faith in drugs.

The knowledge that unconscious hypnotism is not infrequently responsible for the cure of the patient, and that the *vis medicatrix naturæ* is a therapeutic power of no mean proportions, suggests to many skeptically inclined thinking men the possibility that their satisfactory cures apparently resulting from drugs may, after all, be due to one of the subtler influences. Here, therefore, is another contributory cause for weak faith in drug power.

Modern intelligent study of physiological drug action is in some instances another potent factor in weakening faith in the curative possibilities of drugs. The reason why such study has sometimes resulted in this skepticism is, that in the past much of our knowledge of drug action was imaginary, modern methods of investigation having proved this, but they have not yet been extended far enough to fully determine exactly how much or how little drugs will really do. In consequence, the skeptical physician does exactly what the average skeptical mind in all other walks of life does under similar circumstances; he doubts that there is any good in the whole because a part has proved faulty. This is one of the unavoidable results of progress. From implicit faith the pendulum-like mind has swung to the other extreme of pessimistic incredulity, and has not yet had time to reach the ultimate vertical "happy medium." Whether this last quiescence is desirable is a question.

The vast and child-like credulity of some of our early drug provers has to me for many years been a cause for regret. This spirit, unfortunately, has not yet all disappeared from our ranks, but in some minds it still finds harbor, together with some of the intolerance of the dark ages, in proportion to the narrowness of the mind, and out of all proportion to the progressive spirit of the times. Homœopathy is not a theology, a religion, nor is it in any way a sentiment; it is simply a scientific fact. The inherited credulity of the past has been a positive hindrance to the acceptance of homœopathy by many earnest, honest minds; and as long as this spirit of irrational credulity (that regards the honest searcher after facts as a heretic, or in any

other light than as one with the right to examine all things and to have his wholesome doubts), shall sway minds in the profession, so long will it assist in increasing the tendency to rampant skepticism that is now abroad. The poet Moore correctly characterizes this unreasoning state of the human mind when he says :

"But Faith, fanatic Faith, once wedded fast
To some dear falsehood, hugs it to the last."

The vastness of the subject of *materia medica* precludes the possibility of students in pupilage from becoming experts in this branch ; but were "the differences of opinion expressed in the same institution by different teachers" reconciled in their essentials by a more critical and impartial study of pharmacology in general by these same teachers, the student might then be supplied with recitation text-books embodying the vital facts of *materia medica* to which no properly qualified teacher need take exception, and even in the limited time allowed by the college curriculum the student would present himself for his degree examination or his licentiate examination without undue apprehension of the result.

The foregoing may be regarded as some of the many causes which are responsible for much of the lack of faith in the efficacy of drugs to which our attention has been called ; but probably the most potent of all causes is one which has not yet been mentioned, and which at the same time includes some of those named. I refer to a double cause—the absence of both a physiological standard of dosage, and of system in arranging drug effects. Our books are full of alleged drug effects which are supposed to have been produced by a great variety of drug preparations. Even the most devout worshiper at the shrine of antiquity must acknowledge that a proving made with a toxic dose of a drug will not produce the same set of effects, at least in degree, that is alleged as resulting from the 10th or 12th decimal dilution, and yet some persons are so illogical as to accept records of mixed effects of all manner of drug preparations as properly indexing the characteristic effects of the given drug. Without doubt here is serious cause of offense.

After this very superficial review of so important a subject we are surprised at neither the lack of faith in drugs nor in the timidity of candidates for medical degree or license. In fact

we may properly be surprised that so many persons still have sufficient confidence in their ability to practically apply such confused knowledge to the healing of the sick, than that so many doubt. In the light of facts, how is it possible for the average practitioner to have assurance of his ability to heal the sick *tuto, cito et jucunde*, without possessing a clearer understanding of his working material than it appears is possible under present circumstances? As already stated, to reach the goal it is necessary to clearly locate the starting-point and become familiar with its surroundings.

In brief, we find the following twelve causes for the lack of faith in the efficacy of drugs, to which attention has been called:

1. The expectation of too great therapeutic results from drugs, sometimes entertained by young practitioners.

2. The disproportionate progress of surgery, which, when contrasted with therapeutic progress, reacts against therapeutics.

3. The unreliable recommendations of self-constituted authorities.

4. Faulty preparation of drugs, and the influence of the combination tablet; which latter, however, may be regarded as an outgrowth of ignorance of physiological drug effects.

5. Erroneous teachings.

6. Unsystematized records of physiological drug experiments; alleged effects of all amounts and preparations of drug substance being mixed together with primary and secondary drug effects.

7. The different views concerning primary and secondary drug effects.

8. The knowledge that many cures result from the *vis medicatrix naturæ* and from unconscious hypnotism, even though drugs be administered at the same time.

9. The partial investigation of physiological drug effects. "A little knowledge is a dangerous thing."

10. Contradictory teachings in the same college.

11. Fanatical faith, and intolerance of the views of others.

12. The absence of a standard of physiological dosage, and the absence of all system for the arrangement of physiological drug effects.

These twelve causes for skepticism in therapeutics are some of them remediable; some of them are not. Whether they include all the reasons why men will not accept all optimistic things alleged of the therapeutic powers of drugs I do not know, and whether all pessimism would disappear from the medical profession were these causes eradicated I am not prepared to say, but I believe much good would result if each one of us would do what it is in his power to do in this much-needed reform. Some things, however, will remain unchanged, even though all doubt were no longer harbored by the most excursive spirit in our profession, and the physician should always bear the following facts in mind: The cure of the patient may result from, first, the unaided *vis medicatrix naturæ*, second, unrecognized hypnotic influence, and, third, the remedy prescribed. Any one of these influences may be the sole cause of the restoration of the patient to health, or the cure may result from a combination of these causes.

The physician must also further recognize that there are two laws of therapeutics: the law of similars, and the law of dissimilars. Even Hippocrates in his ancient day was aware of the close resemblance and wide divergence upon which to found a study of therapeutics.

Materia medica always will be a difficult study, because the student is compelled to do a large amount of memorizing, but this is no reason why obstacles should be further added to the unavoidable difficulties by teaching false and irrational views.

Drugs will probably always be used as a means of healing the sick, and there will always be those who doubt drug efficiency, but much may be done to remove the disintegrating defects to which attention has been called. Give the average physician faith in his records of physiological drug effects and he will soon forget his skepticism. Strengthen the foundation, clear the starting-point; this is the crying need.

It is unwise for us to jump to conclusions relative to the significance of the attitude of a large number of physicians as to the efficacy of drugs in sickness. Under the conditions noted, it is no great matter for surprise that serious doubt exists; and, further, under these same circumstances it is questionable whether this doubt is not wholesome. The medical profession has reached a stage of education and culture which will in the

future prevent the acceptance of theories, postulates and allegations unsupported by demonstrable fact, and the sooner we recognize this status of the medical mind and strive to unite with the progressive trend the better will it be for the future evolution of truth. To maintain its proper place in the development of the human race medicine must progress. It can never be a completed science nor a perfected art, though it may attain and hold the dignity pertaining to all approximate sciences and arts. Types of men change, the pathology of one century is not that of another, and therapeutics must of necessity progress *pari passu* with all other advances.

SOME ODD REMEDIES AND SUPERSTITIONS IN THE TREATMENT OF DISEASES.

BY FRANK H. PRITCHARD, M.D., MONROEVILLE, OHIO.

Now and then, in practice, one will meet with queer survivals of old-time remedies and superstitions among the people. They are means which the earlier generations used, to try to help themselves out of illness and misery when no physicians were to be had, or when those that they did have at hand were almost as ignorant as the people themselves. For instance, a patient not long ago told me that the skin of a black cat worn around the chest was a sovereign remedy for shingles. That brings to my mind the case of a child in this little town who years ago was suffering from peritonitis. Being given up by the local physicians, a stranger who happened to be stopping at the chief hotel interested himself in the case. As the child was thought hopeless, he asked for a chance to do something. Being given permission, he had the neighbors collect all the cats that they could find. These were skinned as fast they could be killed, and the bleeding skins laid warm over the boy's belly. In all, seventeen animals were sacrificed. The tale, to be complete and to end satisfactorily, relates that the patient recovered.

When I first flung my "shingle" to the breeze, I was called not long after to a case of measles. One of my neighbors, after asking me how the patient fared, told me of an old and

infallible recipe for measles which refused "to come out." It consisted of Nanny Berry Tea, as it was usually called. The dung of sheep was collected and soaked in water, a little sugar added, and the whole boiled until a thin syrup was formed. This was given *ad libitum*. I was assured by my neighbor that it rarely failed. A whole book might be written on the use of feces and urine in medicine. In fact, several years ago such a work was published, its author being an officer in the army of the United States.

One of my English patients related to me that he knew of a man in England who drank his own urine for scurvy, taking a wineglassful every morning of that then passed.

In the same country, in children with thrush or the sore mouth of nurselings, it is the custom to take a live frog and wrap it in a cloth, giving it to the child to suck. I once treated a little child for this disease in a German family where the father informed me that before I had been called all their domestic resources had been tried; amongst others they had taken the child's diaper, wet with the urine, and wiped its mouth out.

Several years ago a Russian physician reported good results in lupus from local application of urine to the ulcers. His discovery came about by one of his patients, in getting out of bed one morning, plunging his foot, on which there was a lupous ulcer, into the receptacle for urine. Noticing that the ulcer seemed improved in appearance by its accidental bath, he continued the liquid locally, eventually bringing about a cure.

I have in my library a curious little pamphlet, by Dr. A. L. Faye, on the management of pregnancy and childbirth amongst the old Norsemen. It is related of St. Olaf's birth that his mother, Aasta, who was at the house of her father, Gudbrand Kula, had long lain with great pain in childbed without being delivered. Her husband's foster brother, Rane, who had just returned home, placed a belt about her which he, led by a dream, had found in the grave of old King Olaf. Shortly after she was safely delivered . . . vardh lettari.

Old weapons which have been dug up are used by the Lapps to lighten childbirth. They are laid in the bed alongside of the parturient woman. Any weapon which has been used to kill a man is employed by the inhabitants of Nordenfjeld to rub tumors, to exorcise them away.

Some time ago I was confidentially given a method of treating umbilical hernia in children. A German woman told me to take a bullet which had been used to kill a steer or a cow—*ein Stueck Vieh*—flatten it out and lay over the hernial aperture, binding over it a cloth bandage. No doubt it would act fairly well.

The ancient Britons were in the habit of having belts which were thought to help childbearing women in difficult births. Ossian, in his poems, mentions them as being amongst the king's treasures.

In Denmark, during difficult labors, it was formerly the custom to breathe the following prayer :

“Jomfru Maria laan mig Noglerne dine
At jeg kan aabne Laenderne mine.”

Walter Scott, “Minstrelsy of the Scottish Border,” ii., 32, has recorded a Scotch song where the son, by cunning, contrived to get his mother to reveal the witchcraft by means of which she had been able to bind his wife's body so that she could not bring forth her child :

“O wha has loosed the nine witch knots
That were amang the ladye's locks?
And wha ta'en out the caims o' care
That were amang that ladye's hair?
* * * * *
And wha has loosed her left foot shee
And let that lady lighter be?”

A very peculiar barbaric custom is mentioned in the tales of the Norsemen people. If a new-born child survived its mother it would be buried alive with her :

“Aller forgloeymer eg den kvie.
Dei tvo smaa baani laag mae doee mo'ers sie.
So hoerde eg dei smaa baani i jori lef.”
(Never shall I forget the cry
Of the two little children who lay on their dead mother's breast.
Thus heard I the two little children in the earth alive.)

This is from Grundtvig's collection of tales. Another from the same source :

“Han lagde Roselille deri med liden troest
 Og begge de smaa levend', la han ved hver sit bryst.”
 (He laid Roselille in there (the grave) with little consolation,
 And both the little children, living, he laid one on each breast.)

PERINEAL LACERATIONS—PREVENTION AND TREATMENT.*

BY EDWIN H. WOLCOTT, M.D.

Female Perinæum.—Definition.—The perinæum includes all those structures which fill the outlet of the pelvis.

Boundaries.—Superficially in front, by the upper border of the os pubis; at the sides and behind, by the thighs and buttocks. The deep boundaries are: In front, the pubic arch and sub-pubic ligament; behind, in the middle line, the tip of the coccyx; upon each side, the descending ramus of the pubis, the ascending ramus of the ischium, the tuberosity of the ischium, and the great sacro-ischiatic ligament overlapped by the gluteus muscle.

The Perineal Body is the cuneiform mass of fibro-elastic muscular tissue located between the lower part of the rectum and vagina. The edge of the wedge is directed upwards, and the base, which measures about 1 inch, or $2\frac{1}{2}$ centimeters, is directed toward the skin. It is composed of the central tendon of the perinæum or central part of the base of the triangular ligament, and fibres of the sphincter vaginæ, transverse perineal, external sphincter ani, levator ani, and deep transverse perineal muscles (Deaver).

For practicality, and for the purposes of this paper, this discussion will be confined to *recent* lacerations of the *perineal body*. Be it understood, however, that the principles herein set forth apply with equal force and propriety to lacerations of any other portion of the perinæum.

Varieties.—The text-books usually classify lacerations of the perinæum into those of the first, second and third degree, according to their extent. Whenever only one-half of the perinæum is injured, the laceration is one of the *first* degree; when

* Read before the Section in Obstetrics of the American Institute of Homœopathy at the meeting held at Richfield Springs, June 18-22, 1901.

the tear extends to, but without involving, the sphincter ani, then there is a laceration of the *second* degree; lacerations of the *third* degree, also called "complete ruptures of the perinæum," which are seldom necessary, extend through the sphincter ani into the rectum.

Our author makes the following classification:

1. Visible tears, varying from a slight rent of the fourchet to a laceration extending into the rectum.

2. Invisible or subcutaneous tears, wherein the muscular fibres and fasciæ are either lacerated or overstretched—a condition permitting great relaxation of the outlet, while the injury is frequently unrecognized, being concealed by the mucous membrane.

There are other injuries of more or less importance, which do not admit of classification. For instance, the so-called "central rupture," wherein the injury is confined to the central portion of the perinæum, and without involving either boundary; tears also extending up one or both lateral sulci of the vagina, even as high as the cervix, resulting in serious injury to the levatores ani muscles; and tears here and there of the vaginal mucous membrane of the perineal body.

Causes.—The various causes tending to produce laceration and relaxation of the pelvic floor are: Occipito-posterior presentations and malpresentations in general; excessive uterine contractions; narrow and too acute pubic arch; weakening of the perinæum from syphilis; excessive rigidity, especially in elderly primiparæ; obstetric operations, particularly forceps delivery (Wood).

Other causes are: Abnormal position of the vulvar orifice; an orifice undilatable or unusually small; unusual development of the fœtus, whether physiological or pathological; diseased conditions of the perinæum, causing rupture under slight pressure; the chin or the shoulder in natural labors; any abnormality in the mechanism of labor which prevents the head from propulsion forward or from proper rotation under the symphysis pubis and carries it backward toward the rectum; cases in which the patient, as the head is emerging, suddenly straightens her legs and brings them together again; and, finally, precipitate labors and labors without skilled attendance necessarily increase the chances of injury to the pelvic floor.

Prevention.—The perineum is lacerated in 35 per cent. of term deliveries in primipara and 10 per cent. in multipara. Undoubtedly in nearly one-half of this number the accident is unavoidable, unless incisions in the vulva are substituted. The most favorable position of the patient to prevent laceration is on the left side. A rapid delivery, especially in a primipara, must be prevented by holding back the head, by commanding the patient to stop straining, and by the use of chloroform, which is of real value in these cases. By this management more time is given for the parts to dilate and become dilatable. A brow presentation or an occipito-posterior position must be changed if possible. The head in hydrocephalic cases should be punctured; "better mutilate a dead child than tear a living mother." When dilatation occurs to a certain degree, then for some reason ceases, the remedy for this condition is clearly episiotomy. It is only occasionally, however, that this procedure is required. Some perinæums will tear anyway, whatever is done by way of prophylactic treatment. Moreover, in strictly normal labors, with healthy perinæums, the muscular conditions are such as to gradually relax under the pressure of the regularly-advancing head without injury to the pelvic floor. The head must be kept well forward against the symphysis pubis, and later under the pelvic arch, by pressure on the sides of the perinæum behind the posterior vulvar commissure, and upon the head itself through the vulva. The forehead should not be permitted to pass the perinæum until the occiput is expelled. When the occiput appears in the vulvar orifice it should be carefully watched. It usually requires at least half an hour in first labors for the perinæum to distend sufficiently to prevent laceration. Generally speaking, in prevention of laceration of the perinæum, the idea is to regulate the expulsion of the head, and not to support the perinæum. We should discourage the introduction of the finger into the rectum for this purpose. It has no additional advantage, and is contrary to the principles of sepsis. Nay, more; the hand should be protected from being soiled with faecal matter by covering the anal orifice with an antiseptic towel from time to time, as may be required. Cases of relaxation of the pelvic floor will occur without laceration of the mucous membrane. These are caused by laceration of the subcutaneous muscles and fasciæ,

and are the more serious by impairing the integrity of the pelvic floor, and are naturally overlooked. In fact, the muscles and fasciæ are more liable to rupture than the mucous membrane. This statement does not apply, however, to the fourchet—the little fold of skin at the posterior commissure, which is torn through in 50 per cent. of all primipara. Much may be accomplished in facilitating labor by the insertion of considerable carbolized vaseline within the vagina.

Treatment.—Recent superficial tears, in fact nearly all tears of the first and second degrees, should be repaired *immediately* upon completion of the third stage of labor. Tears of the third degree should also be repaired at once, unless the laceration extends so far into the rectal wall as to render the operation too hazardous in an exhausted condition of the patient. In cases of large varicose veins in the perineal body, which, if punctured with a needle in suturing, would cause troublesome hæmorrhage and subsequent suppuration, the operation had better be deferred. All operations for recent lacerations should be performed within the twelve hours following labor, if success is to be expected. Otherwise the repair had better be postponed for three months, and until cicatrization is complete. It must be remembered, however, that with delay in the repair of recent cases considerable swelling will occur, and greater difficulty will be experienced in nicely adjusting the lacerated surfaces. By the immediate repair of these cases a secondary operation becomes unnecessary, and infection is to a large extent prevented.

For the technique of the operation you are respectfully referred to the numerous articles in the text-books upon this subject, as it seems to me that a complete discussion at this time would be unnecessary. Two or three suggestions, I trust, will not be out of place. Special attention must be paid to the *repair and suturing of the pelvic fasciæ, the levator ani muscle and the transversus perinei muscles, when ruptured*, to prevent a relaxed outlet, with all its disagreeable conditions, as prolapsus, vesicocele, rectocele, etc.

By a careful study of the action of this special group of tissues (the fasciæ and muscles) it will at once appear that their integrity is of great importance in the preservation of the pelvic floor. When it has been determined that they have been lacer-

ated, whether with or without rupture of the mucous membrane overlying them, three or four deep sutures of silkworm gut should be inserted in such a manner as to include the fragments within their grasp. To accomplish this purpose place the left forefinger in the rectum as a guide, and with a strong needle-holder pass a curved needle as follows: Start the first stitch in the integument one-quarter of an inch from the median line, and about one-half an inch anterior to the anal orifice. Cause the needle to embrace a large area of tissue on the left side, be extremely careful to keep it buried in the anterior rectal wall, and allow it to emerge immediately opposite its entrance in the integument, having included a similar area of tissue on the right as on the left side. The remaining sutures should be similarly inserted, and about one-third of an inch from each other. Tie them tightly, and, if possible, without any clots of blood being included in the wound. For the comfort of the patient and convenience in removal, the use of perforated shot on the cut ends of the sutures is very desirable.

For superficial lacerations catgut, either chromitized or prepared by being sterilized, and placed in a solution of rosin and alcohol in the proportion of one to eight, should always be used, as the ordinary catgut softens under the influence of the lochia before union has taken place.

In the *after care* of these cases it is unnecessary to tie the patient's knees together, as the separation of the thighs and legs does not cause any strain upon the wound. After urination the injured surfaces must be irrigated with a weak antiseptic solution, while hardened fecal matter is detrimental to the healing process, and is to be avoided if possible. To accomplish this purpose two methods are employed. First, by the frequent use of salts and glycerine enemas, beginning the second day after confinement; and second, by preventing a bowel movement for a week or more, when a salts and glycerine enema is employed to soften the accumulation with excellent results.

Remarks.—The tendency in many cases of labor is to neglect making a thorough examination of the perinæum, following confinement, for laceration. This is due to the fact that many seem to consider labor completed when the third stage is ended. This is a great mistake, an injustice to our patients, and the

direct cause of many otherwise needless surgical operations. A ruptured perinæum, however, is frequently the price many women pay for their elevation to more artificial modes of life. As we have emerged from a state of barbarism and ascended the scale of culture and refinement, parturition has gradually changed from a physiological to a pathological process. It is a fact that the difficulties of childbirth increase with the progress and civilization of a people. The savage woman living in a natural state has a more healthy and vigorous frame, and since she never marries except in her own tribe or race, her labor is natural and easy, for the proportions of the child are suited to the parts of the mother; while the parturient woman of to-day, on account of idle living and the relaxed condition of the uterus and abdominal walls, has a greater tendency to malpositions and complications in general. It has become necessary to devise ways and means to meet these new requirements. It is gratifying to state, however, that so far as the subject under consideration is concerned, skillful attendance has materially reduced the number and the extent of perineal lacerations, while the consensus of opinion now favors their immediate repair, unless for special reasons and in certain cases such treatment is contra-indicated.

AN ANATOMICAL DEVIATION OF THE KIDNEY AND URETER.

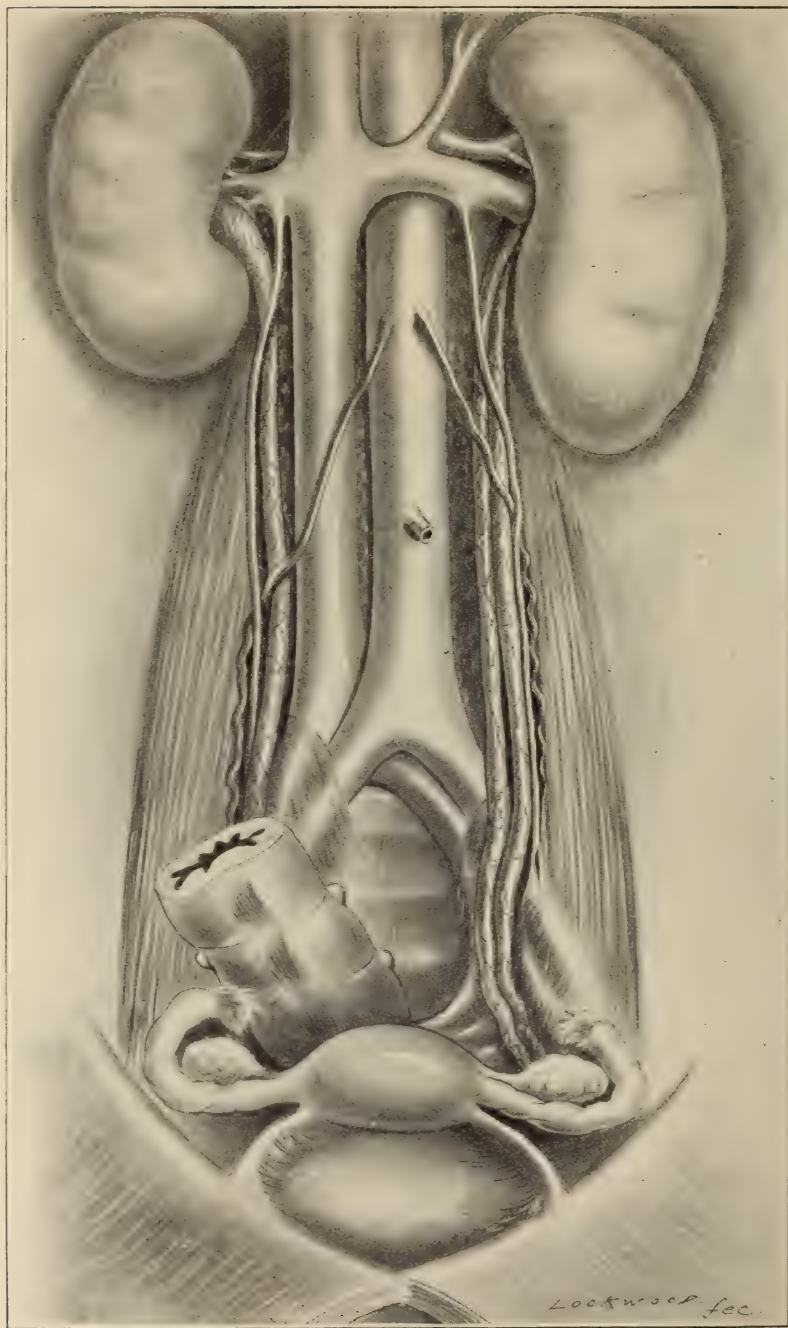
BY IRVING MILLER, M.D., BALTIMORE.

ANATOMICAL deviations of the kidney are much more common than the records would indicate, for it is only of late years that the teacher of anatomy is departing from the routine of anatomical instruction, and emphasizing the fact that man is normally constructed, even if 25 per cent. is not, as text-book plates show. The fact is, students must be taught that the deviations from the accepted type is of more importance, and teaches more than the anatomical plates that have been handed down from book to book. "THE ANATOMY OF RELATIONS AND COMPARISONS" is the anatomy to study and teach; but few schools, unfortunately, are pursuing this course. Its importance, however, is becoming more patent every day.

While working in Dr. Malls' laboratory, last winter, at the Johns Hopkins University, I encountered an anomaly in a kidney that I wish to place on record—not because others have not seen the same, but because it is of especial interest to myself and others who make a specialty of abdominal surgery. This kidney, as you see by the illustration, possesses a double, or, what is more correct, two ureters, which pursue independent courses from the kidney to the bladder, into which they open separately.

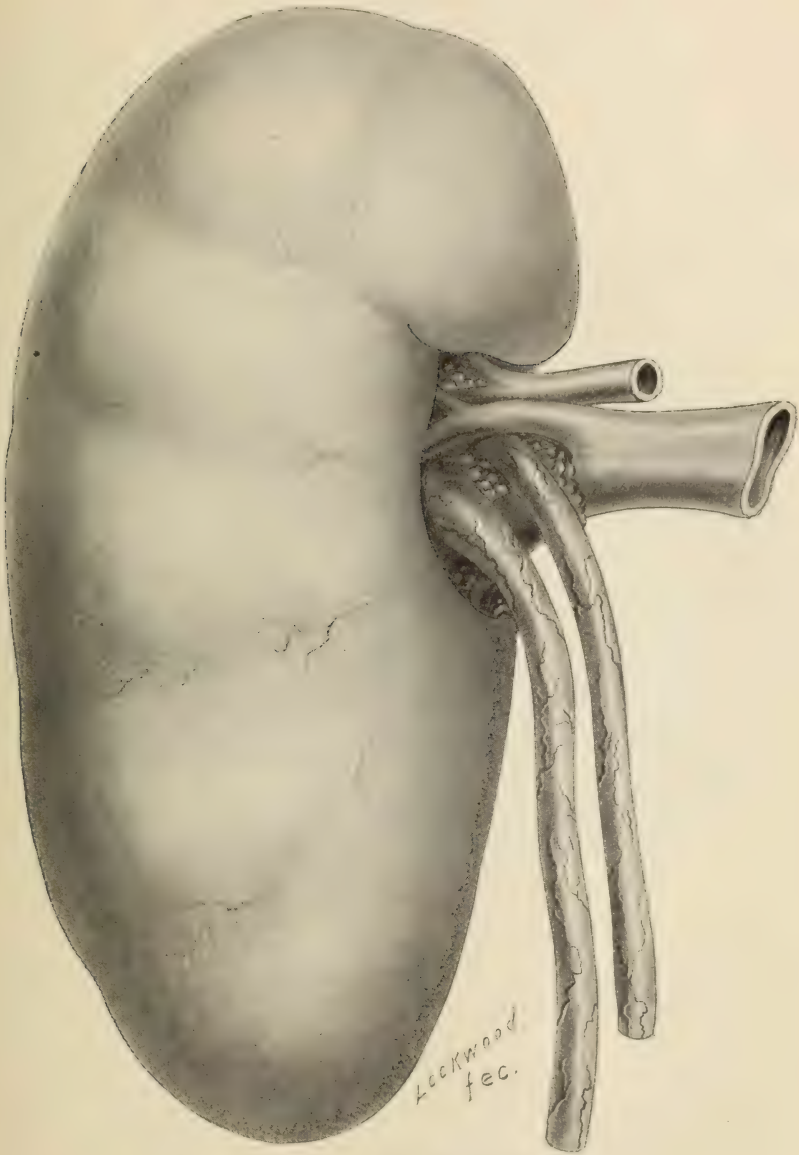
It, being the left kidney, would naturally be a little longer than the right; but in this case the length is 15 cm., breadth 7 cm., and the antero-posterior diameter 5 cm., it being, therefore, a very large kidney. It is decidedly lobulated, which is characteristic of anomalous formations of the kidney, this being a remnant of the foetal type. The kidney is divided into two distinct function-working organs by the cortical substance that surrounds the calices of each respective portion. The lowermost ureter is the larger, and terminates in a pelvis that collects the urine from three calices. The superior or uppermost ureter is not so large, and its pelvis terminates in only two calices. The whole is supplied by one renal artery, and all of its branches are in the anterior half of the organ, with one exception: a small branch not shown in the picture leaves the main branch and passes directly to the lower pole of the kidney. Three renal veins from the main vein collect the blood from the kidney, and two of these veins originate in the lower pole of the kidney, only one branch being received from the superior pole. The ureters pursue parallel courses, and are connected by a loose, frail band of connective tissue. The openings into the bladder are 2 cm. apart, and are perfect specimens of the vesical termination of a ureter. In this case, as one can well see, either ureter could have been catheterized, and the true condition of the kidney need not have been revealed. Divided pelves are quite common, and a double ureter, with one terminating in a blind sac, has been reported by several writers; but a complete organ practically double is not so common. Ramsey, in the *Hopkins Bulletin*, April, 1896, publishes a similar picture, and describes a reduplication which he discovered post-mortem. Also Sommers, in the January number of the *Annals of Surgery*, this year, reports a probable double ureter;

FIG. 1.



but as I have seen the ureters unite in the bladder wall, and only have one opening, it is possible that his case was a similar

FIG. 2.



Posterior view. Natural size.

one. Perfect reduplications are rare; and the literature, while it is enlarging, is yet far from voluminous. Weigert and

Heller have published reduplications with one ureter, being a hydro-ureter, terminating in a blind sac.

Freiberg, in 1899, reported five anomalies of the renal organs; and Ostrowski, in April of the same year, reports an anomaly that is quite interesting. The most important literature at my command bearing on the subject is as follows:

FIG. 3.



Ureteral openings in the bladder.

Ramsey, *Johns Hopkins Bulletin*, April, 1896. Sommers, *Annals of Surgery*, January, 1901. Dolore, *Gazette Hebdomadaire*, 1899, No. 28. J. Kosinski, *Medycyna*, No. 39. Newman, *Medical Press*, May 3d, 10th, 17th, 1899. O. Ostrowski, *Wojenno-Medicinski Shurnal*, 1899. Peters in his *Diss*, 1899. Scudder, *Amer. Jour. Med. Science*, July, 1901.

THE SURGICAL TREATMENT OF EPILEPSY.

BY O. S. RUNNELS, A.M., M.D., INDIANAPOLIS, IND.

(Read before the Surgical and Gynæcological Society of the American Institute of Homœopathy, June, 1901.)

PROGRESS in the medical treatment of epilepsy has been slow and unsatisfactory. Aside from the introduction of narcotics and palliatives, little has been accomplished toward the medical cure of epilepsy. Successful medical treatment has consisted almost wholly in delaying the return of the convulsive seizures or in mitigating their severity. Instances of the cure of epilepsy by medicine pure and simple have been through the ages too rare to serve as a basis for therapeutic systematization. In the treatment of no other malady has empiricism had fuller sway, nor have curative results been less frequently attained. This has been true especially in all the empirical schools of therapeutics.

It was a great gain for the treatment of epilepsy when drug-provings were demanded and the scientific basis of therapeutics was established by Hahnemann's discovery of the law of drug action; but even under the new *régime* cure by medicinal treatment has been a rare attainment, and the recurrence of the epileptic seizures the rule. It has not been sufficient merely to lengthen the interval between the convulsions, to lighten and shorten the duration of the fit, and to get a better record than had hitherto been attained under bromides and the old *régime*; for such accomplishment can be regarded only as a compromise, and in no sense a cure. Cure of epilepsy cannot be predicted until there shall have been no return of the seizures, or until months and years shall have passed without reappearance of the convulsions.

It has been a disappointment to all disciples of scientific medicine not thus to realize the usual result of well-chosen remedies; to be forced to confess that in epilepsy the law of similars was not wholly operative, and that the results of the medicinal treatment of this disease were in very large measure unsatisfactory. But the reasons for such failure are at last

being uncovered. In our insistence upon the removal of all causation before the employment of drug-therapeutics we but fulfil Hahnemann's primal direction, thus giving the drug, if called for, untrammelled range of action. By abating the *causa-occasionalis* at the very beginning of every curative endeavor, the logic of the situation is simplified, drugs are called for only in appropriate cases, and never are employed to accomplish results beyond their capabilities.

Progress toward the cure of epilepsy has been dependent, therefore, upon the closer study of its etiology. It has been contingent almost wholly upon the discovery and removal of certain physical conditions that have served in the given case as nerve-irritants and ever-present disturbers of organic peace. Since the epileptic fit has been regarded as a result rather than as a primary disease, as an effect instead of a cause, light has broken through.

The evolution of the etiology of epilepsy took a great stride in the discovery of the traumatic factor. New light began to dawn when it was settled that epileptic seizures could be produced by depression of the cranial table at a given point, or by the protrusion of bone-spicula into brain tissue. For if abatement of epileptic seizures followed the removal of a thing thus tangible, it was proof that the epilepsy, in that instance, at least, was due to physical irritation.

The indications were none the less pointed in cases of cerebral syphilis; for here, too, in the syphiloma, gumma, or induration incident to that disease, was to be found a measurable reason for the loss of the cerebral equilibrium seen in epilepsy. Here was cause direct, cause immediate, that had unmistakable relationship to this morbid expression.

Further than this, however, induction for decades did not go; there was no persistent attempt to carry the argument to its logical conclusion; there was no real conception of the thought in its entirety. The alienist persisted in confining his investigations to the cranial vault, and regarded that part of the anatomy lying above a plane bisecting the atlas at its junction with the occiput as his particular domain. Spinal cord connection, of course, had recognition; but the claim that insanity—and epilepsy is that—that insanity could have foundation outside the skull was suggestion too flimsy for assumption,

too puerile for debate. Consequently all nerve specialists were concerned with the head; all lenses were focused upon points within the cranium; all alienists were past-masters in knowledge pertaining to the cerebro-spinal nervous system.

The knowledge, however, that the stuff of which brain matter is composed is found everywhere in the system is at last spreading. We now know that the cerebro-spinal nervous system is the lesser half of the equipment; that the sympathetic is the ruler and arbiter of all organic functions; that branch-brains are found in every locality of the anatomy; that each organ of the organism has its own intelligence with joint-relationship to every other organ, and that it has direct connection through ganglionic relays with the great central; that the message of the sympathetic nervous system, as read by the onlooker, differs from that of the cerebro-spinal in that, while with the latter the impression is voiced at the point of impact, with the former it may have no message at all at the initial, but must be read from a distant sympathetic keyboard or at the home office, the cerebral centre, itself.

The "abdominal-brain" was a term coined to emphasize the extra-cranial relationship of the sympathetic, and it has served its purpose. By the amplification of knowledge concerning the anatomy and physiology of the sympathetic nervous system we have come to a better understanding of life-phenomena, and especially of its morbid expressions, and realize more fully than ever before the wide inclusiveness of the sympathetic domain. Searchers after brain irritants and sources of nerve-fag no longer content themselves by intra-cranial interrogations, by delving among cerebral convolutions, and by exploring ventricles, fissures or particular brain areas, but expand their field of investigation to the very boundary of the general integument, and comprehend as never before that pressure upon any nerve-button, however distant, may jangle the caput bell, and may be wholly responsible for almost any expression of physical or psychical discord. The alienist of to-day, therefore, must be a student of the whole man; must be so wide a generalist as to become a good specialist, and should permit no narrow conception to confine his range of vision.

All this is knowledge gained *a posteriori*, from effect to cause, rather than *a priori*, from cause to effect. The theory

was not first framed and facts sought to sustain it; but the facts obtruded themselves, and reasons in explanation were demanded.

The third great step in the evolution of the etiology of epilepsy was made in the recognition of nerve-pinch in the healing of wounds—the impingement of nerve-filaments in the cicatrices, first of wounds of the scalp and next of more distant regions, such as lacerations of the female genitals. From this to the diagnosis of hystero-epilepsy was a short and easy road. Early confirmations were both numerous and conclusive that ovarian and uterine morbidity were responsible for many expressions of psychical disturbance. It was proven that the causes of epilepsy and all allied neuroses were not universally centric, but in many cases—in the majority of cases—the causes were eccentric; that the initial irritation was not intra-cranial, but often extra-cranial, and that investigations wide-afield were called for in all neurotic cases.

Thus it has come about that the diagnosis of the centric causation of insanity and all that that implies can never be made, except by the process of exclusion, until proof has been adduced that no peripheral irritation obtains; until all nagging of sympathetic nerve-terminals has been disproven by actual physical examination.

When it was realized that all children born into the world are handicapped by adhesion of prepuce or clitoris, and that these adhesions are never broken except by manual intervention, the mystery lessened, and the early development of many neurotic manifestations was explained. Irritations incident to eye-strain, to dental complications, to adhesion of prepuce or clitoral hood, to uterine or ovarian embarrassment, to rectal or urethral morbidity, or to any and all kinds of nagging of peripheral nerves, have been proven to be sufficient factors in the waste of life-energy to produce any of the major neuroses.

Hence it has followed that the first step in the treatment of epilepsy and all nervous diseases is to be taken in the abatement of any and every cause of reflex irritation. It is by manual intervention; it is in alleviation by physical means; it is in the removal of the tangible by the tangible.

Is it not very significant that over 60 per cent. of all epileptics have become such before the age of seven years? And

does it not go without saying that the opportune time to treat epilepsy is at the very beginning, when *petit mal* is first announced, or even during the prior deviations recognized in the muscular twitchings, the momentary losses of consciousness, or the inarticulate mutterings of speech accompanied by aimless bodily movement?

If reflex cause could be removed thus early, the cure by prevention would be well nigh infallible—the number of confirmed epileptics would be reduced to the minimum. What can be more alluring than the cure by prevention? Unfortunately, wise foresight is not exercised sufficiently often, and many ill-fated human beings are doomed to almost interminable mental catastrophe; for the longer epilepsy and other forms of insanity are permitted to continue, the more difficult and problematical will be the attainment of cure. Even after the abatement or removal of that which in the beginning was responsible for the mental and physical deviation, the phenomena are apt to be repeated by mere force of habit; and care must be exercised for months, or years, in some cases, regarding environment, regimen, and the exercise of wise foresight. While I am still unconvinced that nerve-centres have undergone organic change in such cases, and that such patients are therefore hopelessly beyond reclamation, I am satisfied that the force of the bodily habit is a very potent factor, and that the patient, thus weakened by long-continued suspension of normal equilibrium, is a cripple requiring every assistance that can be afforded. Many patients of this kind would make more rapid and certain recovery, after thus being relieved of a nagging irritant, if their life-conditions were favorable, if they could be spared all unnecessary worry, fatigue, and over-excitation, and if their environment and psychical atmosphere were of the bracing kind.

And, lest I may be misunderstood in the foregoing, I want to state strongly my belief in the efficacy of the properly selected medicinal remedy or drug at this stage of the treatment. I have said that drugs can have no curative influence so long as the cause of the disturbance is still operative; but I want to say, just as emphatically, that when the thorn in the flesh has been extracted, the *materia medica* will be found to be a storehouse of the greatest fulness, and will afford us in-

dispensable aid in the attainment and regainment of that which has been lost in life-exercise. After the removal of the incubi, instead of leaving nature wholly to herself to make an unaided struggle to gain or to regain her proper status, it is the province of the good physician to minister such assistance as his well-proven remedies shall dictate, and to reinforce the crippled vitality by every means within his power. While the province of this paper is to lay much needed emphasis on an almost overlooked but absolutely essential factor in the radical cure of epilepsy and all allied neuroses, I do not in any way disparage the efficacy and indispensability of drugs when timely administered.

No laboratory experiment ever can be successful when any of its requirements are uncomplied with, and no problem in vital physics can ever be solved until all of its elements are duly considered, and until the plainest dictates of dynamic reason have been observed.

It is just here that homœopathic surgery wins its highest distinctions. It is the supplemental administration of the called-for drug in post-operative treatment that stamps its work as of the highest order. It is the conjoint use of manual and dynamic remedies that makes homœopathic surgery the most up-to-date and successful service of healing rendered the human family at the present time.

But theories and generalizations are valueless unless supported by verifications. No remedy can reach general adoption that does not prove its intrinsic value. While I do not propose to burden you with a long recount of successful cases, I desire to indicate briefly the range of action and mode of procedure in the use of the surgical remedy, and thus to emphasize its opportuneness and great efficacy.

In passing, I want to lay especial stress upon early work for all such cases. I want to emphasize the necessity of manual intervention in every case that manifests for the first time any evidences of the suspension of the will, of involuntary muscular action, of erratic exhibitions, of unmistakable neurasthenia.

Certainly every baby that shows convulsive tendency should have liberation from adhesion of prepuce or clitoral hood, and circumcision, if need be. If this simple matter were to be

attended to universally with all boys and girls before the eighth day of life, as required by the Jewish rite in the case of boys, the nutritional problem of the race would be advanced immeasurably. I am fully convinced that this step alone would rule out almost wholly the second summer difficulties of children exhibited in teething, gastro-intestinal complications, and other expressions of low sympathetic tone. It would put a ban upon the development of many cases of St. Vitus's dance, melancholia, hysteria, hypochondriasis, and that class of neuroses represented by suspension of the will and that are housed eventually in homes for the feeble-minded and asylums for epilepsy and the more advanced types of insanity.

If timely removal of sympathetic nerve-irritants can prevent the on-coming of many expressions of the kind here considered, it should not be forgotten as a first measure of cure after the nagging has continued sufficiently long to produce and establish any neurosis in question. The thing that welcomes "should speed the parting guest."

CASE I.—Willie S., age 17. Had been to his parents an object of solicitude since his birth. For some reason he did not thrive well, made poor assimilation of food in babyhood, and had always been a very excitable and nervous boy. For the last five years this had been shown in fits of anger, and frequently, in his calmer moods, in erratic movements and moments of intellectual suspension, which were afterwards found to be blank in his memory. School had to be abandoned. Light spasms developed, which grew heavier, till frothing at the mouth, with falling and typical epilepsy, was established. The latter had continued for two years when I was consulted. He had adherent foreskin, elongated and only partially retractable, with smegma confined behind the corona glandis. Circumcision and removal of rectal papillæ wholly cured the case. He gained twenty pounds in three months, returned to school, and has given no sign of the old difficulty for over a year.

CASE II.—A girl, age 14, an orphan, mother having died an inmate of the insane asylum. Had been taken from the orphanage at the age of 12 and adopted by a lecherous bachelor for his slave and mistress. This unholy relationship had existed for over a year, when he was convicted and landed in the penitentiary for five years, while she, returning to the or-

phanage, was found to be the victim of epilepsy. She had from ten to thirty convulsions per day and was an intolerable burden of care. Profound narcotics only were capable of delaying the seizures, although medication had been employed for over a year. Upon examination I found the clitoral hood adherent, slight rectal morbidity, and a stenosed and slightly developed uterine.

I freed the clitoris, amputating its redundant hood, smoothed the rectal membrane by removing internal hæmorrhoids and papillæ, and dilated, curetted and packed the uterus, thus inducing mimic labor. The result was magical. For over two months there was no return of the seizures; then she had recurrences, but less often and lighter. I repeated the mimic labor with like good results, but for shorter duration. In six weeks the convulsions reappeared, and continued for several months in spite of internal medication. The seizures were more severe, and were more frequent at the menses. Worst of all, she was found to be unchaste, owing to her antecedent experiences, and the fear of epileptic progeny was menacing. Under the circumstances, and as a last resort, I did pan-hysterectomy per vaginam, after which the storm centre was dissipated. She had no more fits, made rapid physical development, acquired freedom from neurotic manifestations, and was ambitious, entering a training-school for nurses as a student. A year thus passed, when she began to droop, and again became nervous. There was no return of the convulsions so far as known, but she became highly excitable, and finally insane, and was committed to the State asylum. While her cure was not complete, I cite the case as remarkable, charge much of the failure to homeless environment and debauched affections, and express the belief that any treatment that can effect such gain in such a forbidding case is worthy of note.

CASE III.—Twenty-four years of age and mother of one child. Had been very nervous from childhood, but especially so since her labor, a year and a half before. Menstrual recurrences had become increasingly stormy. During the period she would reach intense mental and muscular excitement, culminating in convulsions. Instead of regaining consciousness immediately after the fit, she would enter a comatose, cataleptic sleep, lasting from several hours to two or three days.

When conscious, she was suicidal, and repeatedly attempted to kill herself. After several months of unsuccessful treatment she was committed to the insane asylum, where she was kept for six months under expectant treatment, but growing worse. Opportunity was afforded me for her examination. In addition to hæmorrhoids, she had cicatricial cervix and an enlarged and very sensitive left ovary. Rectal slit work and trachelorrhaphy banished her horrible experiences. Within a week she returned to herself, had lost her suicidal mania, and had no return of her epilepto-cataleptic seizures. She had gained in weight rapidly, and assumed her duties of wife and mother. Nine months later, at the menses, she detected symptoms of recurrence, and returned from her distant home for examination. The sensitive ovary had become cystic, and as large as a small cocoanut. Pan-hysterectomy, per vaginam, proved the cyst to be a dermoid, containing long hair and embryonic elements. Recovery was uneventful and complete, nine years having now elapsed in perfect health.

CASE IV.—A maiden, aged 27. Had had typical epilepsy for fourteen years, and had been badly burned by falling into the fire during a fit. Her long-continued prescription of bromides and lady's slipper had at last failed to control the convulsions. Search for peripheral cause revealed clitoral hood adherent, uterus infantile, pile-bearing inch hæmorrhoidal. I did all-around orificial work, including the induction of mimic labor. The result was gratifying, as there were no convulsions for six weeks; then they returned. Again I dilated and packed the uterus, forcing prolonged labor effort, and again there was a cessation for several weeks. The recurrence the third time was only at or during the menses. After several months I did ovariectomy, leaving the uterus. Once more there was a prolonged cessation, only to again recur. Almost in despair, except for the presence of the diminutive uterus, exceedingly sensitive, I made a last endeavor by doing vaginal hysterectomy. Before the anæsthetic had worn off after the surgical work there was a light convulsion, but only one—the last appearance. The play was over; the troop of players had been disbanded. She has been wholly well for a year and a half.

But a repetition of cases is not called for further. Others have had parallel experiences. Ophthalmologists and dentists

have succeeded in curing epilepsy by relieving eye-strain or dental deformity, the physical irritation that had goaded its victim till toleration had been exhausted and nerve protest had become loud and insistent.

Be assured that epilepsy is an effect; that the cause is, in most cases, definable and removable, especially at the beginning, and that cure is dependent upon the latter accomplishment.

A CRITICISM.

BY THEODORE L. CHASE, M.D., PHILADELPHIA, PA.

THE article by Dr. Bullard on "The Medical Treatment of Appendicitis," in the August number of *THE HAHNEMANNIAN MONTHLY*, presents deductions so opposed to the observations of a majority of physicians that I cannot refrain from criticizing it.

The medical treatment of appendicitis after the first few hours is no treatment at all—simply medical observation, accompanied by sins of omission. If the medical treatment of even one hundred such cases, no matter how learned and careful in the selection of their remedies were the prescribers, could be followed by the profession at large, they would be appalled at the mortality rate. If the young physicians now beginning practice were to follow the dictates of that article, in their experienced after-years they would have many moments of bitter regret over the patients needlessly permitted to pass into eternity.

The author stated that "the appendix vermiformis is an organ which has its place in the economy of nature." The facts, as stated by eminent pathologists, are as follows: The appendix is attached to the inner surface of the head of the colon, a rudimentary organ, the rudimentary vestige of what is a well-developed cæcum in the herbivoræ. Histologists tell us that its tissues are below par in resistance, as compared with the other tissues of the intestinal canal. We have only to consider the gross anatomical features of the appendix, the low-grade structure of its internal and middle coats, and its blood supply

through a single artery, to comprehend why appendicitis in a few hours becomes a strictly surgical disease. During the past eleven years I have seen an average of thirty-two cases each year, and in 1895 I treated ninety-six cases; so that my opportunities for observation have been as great, probably, as those of the average practitioner. Thirty-two cases were operated, with three deaths; of the latter, two were fulminating cases, and one died from septicæmia on the sixth day. In addition, three deaths from septic peritonitis occurred in cases where operation was delayed or refused. Upon retrospection, I feel safe in asserting that without surgical interference there would have been twenty-five deaths instead of three. The following citations of a few cases will explain themselves:

Mr. R., 44 years of age, was taken ill with vomiting and colicky pain in the abdomen; he had been constipated for several days, and very sensitive over McBurney's point. Merc. dulc. was given, followed by a saline aperient. This relieved the bowel, but the sore appendix remained. Pulse 82, temp. 99.6°. Upon opening the abdomen the appendix was found erectile and moderately swollen, with its basal end occluded. This patient made a good recovery.

Mr. G., aged 44 years, began his attack with vomiting, diarrhœa, and colicky pains over abdomen. He was most sensitive over appendicular area. Pulse 85, temp. 100° to 103° for first two days, then gradually coming down to 99°, whereabouts it remained throughout the following week. The bowels were moving daily, and the patient was improving in every way except the sensitive appendix, detected upon pressure. I had great difficulty in keeping this patient in bed, for he insisted that he was well, as far as his view of the case was concerned. Owing to the fact that some soreness remained, I asked for consultation with a view of operative interference, and Dr. Wm. B. Van Lennep was sent for. After the latter looked over the history and examined the patient, we explained the facts to Mr. G., and after some hesitancy he consented to have the abdomen opened. Here I should state that the dangers of a relapse were laid before him for reflection, and this caused his final decision. This case illustrates the desperate state of affairs within the peritoneal cavity when every sign, excepting one, led us to believe the patient was improving. When the appendix was

reached it was found free from adhesions, distended, and gangrenous to such a degree that it ruptured almost completely through the entire organ under the most gentle touch. The wound was packed with iodoform gauze, secondary suture being made on the sixth day after operation, and primary reunion followed this procedure, with uneventful convalescence.

Mr. C., 21 years of age, began his attack with high fever, severe abdominal pain, and on the second day a distended abdomen. He was treated medically by a practitioner in the country for three days, when I was called in. He was immediately sent to the hospital, and a pint of pus liberated from his right iliac fossa, followed by slow but complete recovery.

Mr. R., aged 24, was treated at his home for indigestion. I saw the case at the close of the second day, and found a temperature of 100.5° , and a pulse of 82. The area about the appendix was exquisitely sensitive to slight pressure, and there was some rigidity of the right rectus. Diarrhœa continued throughout the attack. This case was sent to the hospital the same evening, and the abdomen opened at midnight, revealing ruptured appendix, with free pus in the peritoneal cavity. The wound was packed and allowed to granulate; recovery followed.

Similar cases could be cited indefinitely with like results. Physicians within reach of our hospitals are able to see the evidences furnished by early operation in appendicitis, but the men who are in the remote country districts, who have not had the benefit of this training, should be guided by the opinion of the experts who are constantly having a wide experience in this life-saving work. The evidence is so conclusive that physicians who have had one slight attack will undergo the inter-period operation for the sake of safety. Illustrating this fact, some four years ago I was present at an appendectomy with four other physicians, and we five onlookers, on comparing experience, found that four of us had subjected ourselves to the same operation, performed by our mutual friend, Dr. Wm. B. Van Lennep. The writer of the article ridiculed by Dr. Bullard says there are but two safe places for an appendix: "One in a book, and the other in the surgeon's vest pocket." Yet more true would it be to say that the *safe* place for a diseased appendix is *anywhere*, as long as it is outside of the patient's abdomen.

Dr. Bullard quotes from other physicians as follows:

"I have never had a case operated, and never lost a case."

"I have never had a case where I thought surgical interference necessary, and have taken all my cases through to perfect health."

"These cases will all bear investigation, and are alive to tell their own story. Believing that many hundreds of cases are treated and cured without the knife, I remain," etc.

"Eighteen cases recovered without surgical aid, and seem to have completely recovered. Two sent to the hospital for operation, and both died."

"All were treated with homœopathic remedies successfully, and there has been no recurrence in any case."

"Have never lost a case, and have never had one operated."

Well! The more quotations, the more we wonder! Dr. Bullard states that 230 cases were reported, 228 of which were treated medicinally. There were two deaths; both operated. The indicated remedies were those usually selected by homœopathic physicians, and of these each one has its range of cure; but when the case is over twenty-four hours old and not improving, a rapidly developing pathological degeneration is silently but surely carrying your patient beyond the range of therapeutic measures. I know of no such records. The mortality rate of the medical treatment of appendicitis has been enormously high, compared with the cases treated surgically in the early stage. I would say to the physician who would treat his cases medicinally, "Do so, but do it quickly." After a few hours have passed and the case has not improved, then it becomes a surgical case. As to "one hundred cases of appendicitis treated without a death," I have nothing to say except of a like remark made by a physician who treated 400 cases of diphtheria with sulphur without a death. "There are cases of diphtheria." There are cases of appendicitis. The law of coincidences can be used to a large extent in diverse fields of observation.

"Flaxseed poultices over the sensitive area." I should say there was no better coaxer for appendiceal inflammation, and if the poultice were used in a sharp attack it would tend to keep the inflammation there. As a summary for treatment I would suggest: The indicated remedy, a saline aperient sufficient to

secure a thorough bowel movement, an ice-bag over the right iliac fossa, and if no improvement occurs within twelve, eighteen, or at most twenty-four hours, have the abdomen opened and the offending organ removed.

The second volume of Dr. Goodno's *Practice of Medicine* contains an able article on appendicitis, and we all know the exceedingly large experience the author has had in treating that disease from the medical standpoint. He states that "notwithstanding the fact that about 80 per cent. of all cases of appendicitis end in recovery without operation, the disease must be regarded as a highly dangerous one; for no matter how mild the symptoms may be, or how apparently trivial the illness, the case may suddenly assume a most malignant type, passing beyond the control of the most expert treatment.

"Ten to fifteen per cent. of cases will die but for surgical aid. If this warning is not heeded, we have here the cause of a high mortality of appendicitis." Look at Plate 1, Figures 1, 2, 3 and 4, showing diseased appendices taken from cases operated by Dr. Fowler, whose treatise on appendicitis was published in 1894, and who would say that medical treatment could cure the cases from which these specimens were removed?

Dr. Fowler remarks that the prognosis of appendicitis is unfavorable in the cases treated non-operatively in proportion to the severity of the infection, and in the cases treated surgically in proportion to the delay in instituting operative interference. The above is as true to-day as when it was written.

There is one other phase of the disease under discussion, namely, the so-called adhesive or "walled-off" cases. Here, if the practitioner was in attendance upon the case from its incipency, the golden opportunity for removal of the appendix has passed. The slow (comparatively) degenerative changes going on to abscess formation could all have been prevented without this distressing complication, which causes our patient to run a terrible risk, and even if the case ends favorably necessitates a prolonged convalescence.

EDITORIAL.

STATE APPROPRIATIONS FOR HOSPITALS.

THE recent State appropriations for the various hospitals of the Commonwealth have occasioned considerable public and private comment, and one is perplexed to know on what basis the grants of money were made.

It is conceded by right-thinking men that some appropriations were made without warrant, some were much larger than were justified, and some so small, when the worth and needs of the institutions are considered, as to be almost an insult.

It appears that the various officials of the State are not at all in accord. The State Board of Public Charities takes one view of the necessity for certain appropriations, the Legislature another view, and the Governor still another, and so every interested spectator is wondering what will be done as various stages of the *modus operandi* are reached; and at the end, when the Governor's approval has been given or withheld, honest business men wonder how it has all come about: those who have received more than was expected are elated, those who have received little or nothing are depressed, and the judicious are grieved.

During the progress of an appropriation bill, from the time of the application before the State Board of Charities until the final act of the Legislature, much interest is enlisted, and many are the queries as to modes of procedure to secure appropriations wished for, or deemed necessary, by the supplicants for State aid. To one who has followed the matter closely, it has been surprising to learn of the various and divers methods alleged to be resorted to. We enumerate some of them: 1. To ask for three times as much as is needed, on the supposition that the State Board of Public Charities will cut down some, the Appropriations Committee of the House will make a big cut, but, after all, more will be obtained than is actually required for legitimate use. 2. To secure a lobbyist, who

will get all that is wanted, if he is authorized to "divvy." 3. To secure a "pull" by enlisting in favor of a bill some influential politician. Get Senator ———, or Mayor ———, or "Boss" ——— to work for it. 4. To send a strong delegation to Harrisburg when the bill is considered by the appropriations committee, and to be prepared to answer any and every question propounded by its chairman or any member of the committee. 5. To keep away from Harrisburg, as the members of the appropriations committee don't want to be bothered. 6. To rent a house in Harrisburg, stock it well with wines, and entertain legislators by lively "vaudeville performances." That sort of thing will bring the money when nothing else will. 7. To elect on your hospital board of directors "respectable" men who know nothing of its needs nor operations, but be sure to have one presiding genius who can go to Harrisburg and dictate the amount to be appropriated to the Legislature and Governor. 8. To invite the members of the Legislature to come to your city, and give them a good "blow out."

Newspapers, and apparently well-informed citizens, have averred that all of the above methods, and others that might be mentioned, have been resorted to, to gain the coveted prize. And when one contemplates the results as finally given in the daily press, when the Governor's "action" is published, it is little wonder that many people believe vicious legislation anent appropriations for hospitals has been enacted, and that venal methods have been resorted to.

We are led to conclude, if any respect is to be entertained for the business qualifications or the probity of our State officials, that the basis of all appropriations to aid hospitals should be *worth*. Abundant opportunities are afforded the State Board of Public Charities, the visiting delegations of the House and Senate Appropriations Committees, and the State Executive himself, to ascertain beyond any peradventure of doubt which of the hospitals of the Commonwealth require State aid, and to what extent every worthy charity should be helped.

To this end we suggest: 1. That after a thorough explanation by an official or trustee of any hospital what the needs of the institution are to bring it to its highest degree of efficiency,

and after due investigation of the work the hospital has done, and a careful consideration of the prospective demands for enlarged charity, the State Board of Public Charities shall recommend the appropriation of certain sums for specifically named purposes. 2. That the Appropriation Committees of the House and Senate shall visit the hospital seeking State aid, and by personal investigation satisfy themselves that the appropriation recommended by the State Board of Public Charities is justified. 3. That after a careful estimate of the revenues of the State by the Executive, and the chairmen of the Senate and House Appropriation Committees and of the Committee of Ways and Means, the amount to be specifically appropriated to every hospital shall be determined impartially by concurrence of the Governor, the Appropriation Committees and the State Board of Public Charities. 4. That no political or personal influence shall have the least weight in the determination of the amount appropriated to any hospital, the question in every instance to be determined on purely business principles and justifiable claims as to *charity*.

SECTARIANISM.

THE more we study the subject of evolution and development the clearer becomes the universal law according to which it takes place, manifesting itself throughout the universe in every sphere of activity, be it physical, mental or moral. It is the general law of progression from the whole to its parts, from generals to particulars. It determines essentially an analysis, by which each part is made for a time successively the starting-point of a new analysis, whereby, finally,—if the process is capable of being finished,—the content of the original whole is completely represented by all its fully developed parts. These parts originally represent only potential capabilities, which, however, by this process of unfolding become actualities distinct from, yet genetically connected with, their origin.

The operations of this law can be studied in the evolution of the solar system, of mineral, plant and animal life as a whole, of the species, and finally of the individual. What more beau-

tiful and striking illustrations can be found than those furnished us in biology in the gradual differentiation of functions and organs traceable throughout all forms of life, and so wonderfully exemplified in the growth of the human embryo?

It may seem ridiculous, or at least very far-fetched, to introduce a few considerations on the subject of sectarianism by reference to a law of evolution, and yet we think that only thus can a standpoint be gained from which the subject may be viewed impartially.

The words sect, sectarian and sectarianism have usually a discreditable meaning attached to them, and our enemies can find no more weighty weapons to hurl at us in private and public than these very terms. Homœopathy forms a sect; homœopaths are sectarians; if they would only drop their sectarian title, etc. Many among our own number seem to regard the terms with the same disfavor, and imagine that by dropping them they are advancing the cause of medicine and testifying to their own liberal scientific attitude. From the point of view above laid down we can see at once that this is not the case, but rather that it is a step backwards, because it is not in line with the universal law of progress; that it is a premature attempt to reunite parts which in themselves have not been sufficiently developed to form a complete whole. The parts being incomplete, their union would not represent the content of the whole from which they were originally derived, and to which they are still genetically connected.

Sectarianism is not only useful, but it is necessary. Far from being ashamed of sectarianism, homœopaths, as well as all other sectarians, in whatever field they may be found, should glory in the fact that they have been called upon to perform some special work, to search after some special form of the truth, to fill some special niche in the temple of knowledge. Sectarianism is nothing but specialism viewed from a somewhat different standpoint. We do not mean an intolerant, bigoted sectarianism, such as is usually implied when the term is employed as one of reproach; for, although the determination and willingness to pursue a road different from that traveled by others implies somewhat of these characteristics, these latter do not form essential or necessary features of sectarianism. In what does it differ from specialism? Only in

this, that in it there is a more formal and distinct cutting loose from partially parallel lines of activity, and in so far is apt to assume a somewhat more aggressive attitude than does specialism. The specialist is father of the sectarian. So long as the specialist finds nothing in his chosen line of thought and work too much at variance with the views of his colleagues he is content to remain a specialist; but when the differences become too great or too numerous, he is obliged to cut himself loose, either formally or by implication, from his fellows, even if they still have many points in common.

In medicine, in spite of the extreme limit to which specialism has been carried, its necessity has come to be recognized, and theoretically it cannot be carried too far. For the development of the science of medicine in its multiform ramifications there can hardly be set limits to profitable and fruitful specialism, but in its practical application to the art or practice of medicine these limits are sooner reached. If the relation between specialism and sectarianism be such as we have indicated, it follows that in the realm of pure scientific medicine great differences of opinions and theories may exist without calling for or justifying the striking out of a new way or the founding of a sect; but so soon as theories are made the basis of practice, then contrary or divergent fundamental views, leading to conflicting methods, must inevitably lead to sectarianism. We can trace this genesis of the sect in the church as well as in medicine. The various dogmas and tenets of the early centuries of the Christian church coexisted within the same fold until their application led to practices which compelled the separation of some from the main body and the formation of sects. In the medical world it was not the differences in opinions but in practices that led to the cry of sectarianism.

Besides being thus a necessary stage in the development of medicine, in the sense of being an unavoidable accompaniment, it is necessary also as an essential factor in this development.

As we have seen, the sect does not arise until its truths and methods have assumed such importance in the eyes of its members as to compel the separation. This introduces an element of enthusiasm, and often, we might say almost always, an in-

tolerance of dissent which is unfortunate but human, and eventually results in the most thorough and exhaustive elaboration of the peculiarities of the sect, ending either in their universal recognition or in their rejection or modification. It is only thus that we can hope for a perfect, thorough development of medicine. So long as Hahnemann propounded theories he was tolerated; when he changed his practices he became a sectarian and was excommunicated. So long as we, his followers, do not regard his views and our own on the fundamental principles of therapeutics as of paramount importance, we are allowed to remain within the fold of the regular school as physicians, to practice as we like; but when we become convinced, or as long as we remain convinced, that our views demand a different practice, and when we urge an investigation into its merits and strive for its recognition, then we become sectarians.

Homœopathy is a specialty. It makes therapeutics the main issue. This is a practical issue, and was so fundamentally at variance with the principles and practice of the old school that the foundation of a sect was imperatively demanded. Homœopathy is a sect in the true sense of the word; homœopaths are sectarians, and their title is also sectarian; and this will continue to be so until, in the process of investigation, such modifications and limitations of the present views shall result that a higher plane will be occupied, on the basis of some newly-discovered phase of truth. Even now we see indications of this, and we have reason to consider homœopathy as containing the nucleus of a new school of medicine, not as this word is generally used, but in the sense to which reference was made a couple of months ago. When this consummation is reached, the name Homœopathy, together with all its sectarian character, will naturally and of itself fall away, for it will no longer express the whole truth. Until then, let us glory in our enlightened sectarianism.

ABOLITION OF THE PUPILLARY REFLEX AND SYPHILIS.—Dr. Babinski, of Paris, claims that permanent absence of the pupillary reflex in cases where it is not dependent on a disease of the eyeball, optic nerve, or a paralysis of the third pair of cranial nerves, is practically always due to hereditary or acquired syphilis. Such a patient is a candidate for tabes, diffuse meningo-encephalitis or cerebro-spinal syphilis.—*La Semaine Medicale*, No. 22, 1901.

GLEANINGS.

RESULTS OF TREATMENT BY MEANS OF THE HOT-AIR APPARATUS.—Drs. Neumann and Zimmermann have used the Tallemann hot-air apparatus in the treatment of gout, chronic arthritis deformans, chronic rheumatism, sciatica, lumbago, and in the results of traumatic and inflammatory joint affections, with excellent results; in fact, Dr. Neumann is quite enthusiastic over it. Dr. Zimmermann, though more reserved, admits its great usefulness in these conditions. In a case of scleroderma it yielded favorable results. It is wholly without danger, even in persons with diseases of the heart and blood-vessels. There need be no fear of burning the patient if the skin be well anointed.—*Hospitalstidende*, No. 20, 1901.

Frank H. Pritchard, M.D.

ATROPINE IN A CASE OF ILEUS IN A HÆMOPHILIAC.—Dr. Middeldorp, in a patient, an architect of 58 years, who came under his observation, with symptoms of intestinal obstruction, where an operation was contra-indicated on account of hæmophilia, succeeded in restoring his patient to health by the hypodermatic injection of atropine. The patient was vomiting fæces, his temperature 36.8° C., his abdomen very much distended, no hernia to be detected. His urine contained an excessive quantity of indican and biliary pigments, no sugar, and a slight trace of albumin. He was certainly subject to hæmophilia, for he had had, at times, serious attacks of hæmaturia, as well as subcutaneous hæmorrhages. He had had neither purpura hæmorrhagica nor the rheumatic form. When first seen he was so collapsed that he was given three hypodermatics of camphorated oil. Though his stomach and bowels were irrigated, the latter both in the dorsal and in the knee-elbow positions, no stool was obtained. All his internal organs seemed normal, and occlusion by hernia, volvulus, strangulation or a neoplasm could be definitely excluded; all operative measures were inadvisable on account of his being a "bleeder." Hypodermatics of atropine—one mgm., one and a half and two and a half mgms.—were given in the course of two days. He became very pale, unconscious, and fell into a maudlin state, while his pulse remained strong. Temperature, 37°; pulse, 110–114. A prompt result followed the use of atropine, for a hard stool was passed, followed by several thin ones of the consistency of porridge. He was discharged as cured in a few days. The writer thinks that atropine in this case actually was the means of saving life. *Muenchener Medicinische Wochenschrift*, No. 17, 1901.—(In another article on the same subject, in the same number of this journal, Dr. Adam employed the drug in a similar desperate case of intestinal occlusion, but used at the same time olive oil internally, in doses of about two ounces every three hours. I have given the oil with atropine under the skin, and I have been more than pleased with the results.)

Frank H. Pritchard, M.D.

INTESTINAL PSEUDO-LITHIASIS DUE TO DRUGS.—Dr. de Langenhagen observed a woman of 48 years who, for a year, had been passing daily through her bowels calculi, which were quite voluminous, and of a grayish-yellow color and chalky in consistency. They were found to consist of a mixture of bicarbonate of soda, the carbonates of lime and magnesia, which drugs she had been taking for a long time, in powders, on account of some stomach affection. Leaving off the powders was sufficient to cause the curious calculi to disappear.—*La Semaine Medicale*, No. 19, 1901.—(Years ago I read in an old copy of the *Boston Medical and Surgical Journal* of a patient who passed in her feces some gallstone-like concretions, which were found to be masses of a soapy substance which had been formed from the olive oil which she had been taking for cholelithiasis.)

Frank H. Pritchard, M.D.

THE CLINICAL FEATURES OF CIRCUMSCRIBED GUMMA OF THE BRAIN.—Dr. Herber, from a study of this form of brain syphilis, has found it to be rare, differing from other cerebral tumors by focal symptoms, and being complicated by superadded signs of other syphilitic lesions, as arteritis, meningitis, etc., which the growth itself does not explain; this polymorphism of symptoms is pathognomonic.

The gumma rarely runs an acute or chronic course; it is ordinarily characterized by a series of episodes, which develop slowly, of five to eight months' duration.

After a so-called "silent" period, the brain begins to present, symptomatically, signs of intolerance. In cortical gummata the beginning is marked either by epileptiform phenomena, meningeal disturbances or mental troubles; those of the central ganglia are characterized by sudden or progressive hemiparesis.

The symptoms of the fully-developed disease are: (a) almost constant headache by day as well as by night, which resists all manner of treatment except antisymphilitic; (b) vomiting and constipation often are associated; (c) a choked disk is frequent, though this is common to all brain-tumors. Epileptiform symptoms are very frequent, from simple convulsions to distinctly localized Jacksonian epilepsy; this latter is usually a symptom of pressure, and not of value in localizing. Hemiplegia often betrays the presence of a gumma; in cortical lesions it is postepileptoid, but little marked, transitory and recurrent. In affections of the great ganglia it is persistent. Ocular paralysees are not rare, but they are usually dependent on a lesion concomitant with the gumma. Besides, there are mental symptoms, as a more or less profound state of stupor, hebetude, apathy, or symptoms of dementia simulating simple mania or general paralysis.

Left to itself, circumscribed cerebral gumma often brings about death, either in coma, with meningitic symptoms, or by marasmus and cachexia. At other times death is due to some other intercurrent disease, either syphilitic or not. A recovery is possible, as necropsies have shown gummatous cicatrices or calcified gummata.

The treatment should be hygienic, medical or surgical, according to the case. Hygienic management of the digestive tube to prevent autointoxication, so as to hinder congestion about the growth, is worthy of attention. Medical treatment should be energetic, with a combined action of mercury and the iodides. But even this may be useless for secondary changes, as

hæmorrhages, softening and sclerosis may have occurred. Surgical treatment is limited to drawing off the cerebro-spinal fluid.—*Journal des Praticiens*, No. 20, 1901.

Frank H. Pritchard, M.D.

A CASE OF ACUTE MALIGNANT ACROMEGALY.—Dr. Gubler observed a woman of 30 who became ill with symptoms resembling influenza, lost her menses, and six months later a left-sided amblyopia set in, which later improved. In a year and a half the other eye became affected in the same manner. Hysteria was thought to be at the bottom of the case until paralysis of the facial and trigeminal nerves complicated, to be followed by signs of acromegaly, with headache and atrophy of the optic nerve, so that by two and a half years after first being seen she presented typical symptoms of acromegaly. The patient died three and a half years after the beginning of the disease, and at the necropsy, instead of the normal hypophysis, a tumor, soft, and of the size of a goose-egg, was found at the base of the brain. On superficial examination, one might regard it as a small and round-celled sarcoma, on account of the size, form and diffuse arrangement of its cells. Careful investigation showed it to be of epithelial origin, and as a derivative of the small, normal epithelia of the hypophysis cerebri. Hence the growth was really a diffuse, tumor-like hyperplasia of the hypophysis—a struma parenchymatosa hypophyseos. Some cases of so-called sarcoma of the pineal gland have been of this nature. The majority of writers regard acromegaly as an analogue not of myxœdema, but of Basedow's disease; therefore, not from a lack of, but from an abundance of glandular secretion.—*Centralblatt für Chirurgie*, No. 19, 1901.

Frank H. Pritchard, M.D.

TREATMENT OF ACUTE NEPHRITIS.—(Perrier.)—In the treatment of acute nephritis two important points should be kept in mind: (*a*) relief of vascular engorgement of the kidney, (*b*) elimination of the toxins in the blood as the result of deficient urinary secretion. The patient should be put to bed and given hot drinks and applications of dry heat by wrapping in woolen blankets. In case these means fail to promote skin action the hot-air bath should be used. Nausea and vomiting may call for relief, and in such cases ice, carbonated waters, teaspoonful doses of hot water may be used at frequent intervals.

The diet should consist of koumyss, equal parts of milk and carbonated waters, fresh buttermilk, barley water, light broths, excluding concentrated meat extracts. The diet may be gradually increased after the acute symptoms have subsided. Alcoholics should be interdicted. Where the urine is very scant or suppression exists, hot linseed meal poultices, containing a tablespoonful of mustard, should be applied every four hours. If the symptoms remain urgent the hot pack should be employed. Failing in this, the subcutaneous injections of saline solutions should be used, one quart being administered every six to twelve hours until relief of symptoms. High enemas are not so effective.

The most effectual cathartics in uræmia are elaterium and croton oil in one-half drop doses repeated every hour until the bowels are moved. The oil may be rubbed up with a small powder of sugar of milk, or can be combined with calomel and placed on the patient's tongue even when unconscious.—*Cleveland Med. Gazette*.

William F. Baker, A.M., M.D.

GONORRHOEAL MYOSITIS.—(M. W. Ware.)—The clinical observations concerning the finding of the gonococcus in muscle have been of recent origin. The history of a case as given is that of a male, aged 35, who had contracted gonorrhœa two months previous. In the fourth week he had a metastasis in the left knee-joint, which rapidly yielded to treatment. Later he developed severe pain about the shoulder-joint. In the manipulation an induration about the size of a walnut was found in the group of muscles that make up the posterior axillary fold. The daily elevation of temperature was about 100° F. The pain became so intense that the mass was incised. No pus was encountered, but a free oozing of turbid serum resulted. This serum was utilized for microscopic investigation, as was also the piece of muscle which was removed. Cultures were made on agar-agar and sugar bouillon, which showed the gonococcus. The section of the muscle showed an interstitial inflammation. Judging from this case and several others cited, it is probable that a large number of cases reported in females, classed as pyæmic, following the puerperum, rest on a basis of gonorrhœal infection. That the bones can be the seat of a gonorrhœal osteomyelitis, the recent experience of Ullman bears testimony. As to the method of infection, we can reason by analogy from associated conditions that the primary seat of the metastasis is in the bone and joints, and follows by extension into the muscular lymphatics.—*American Journ. Med. Sciences.*

William F. Baker, A.M., M.D.

THE TREATMENT OF CONGENITAL DISLOCATION OF THE HIP-JOINT.—Ely (New York) describes three methods of treatment :

(1) The closed method, that is, without the aid of the knife, as practiced by Lorenz. Briefly, it consists of putting the head of the femur where it belongs, under an anæsthetic, and keeping it there in such a way that the weight of the body and constant muscular tension may press it into the socket. The child (usually a girl) should be between the ages of 2 and 10 years, in the case of single luxation, and not over 7 years in double dislocation. The older the patient the less likelihood of the operation proving successful. Preliminary treatment in the way of extension or tenotomy may be necessary in some cases, when the soft parts are unyielding and the head cannot be brought near to the region of the acetabulum. In a case of single dislocation the head is replaced by means of the following manipulations: First, the resistance of the adductor group of muscles is overcome by forcibly abducting the limb and by a species of massage with the ulnar border of the hands upon the adductors close to their insertion in the pelvis. The next step is forcible extension, counter-extension being made on the protected perineum, and often the head may be felt to slip in and out of the acetabulum during this manœuvre. Finally, the head is lifted into the socket over the posterior border of the acetabulum by grasping the thigh flexed at right angles to the trunk and rotated slightly inward, with one hand just above the knee, making strong traction in the direction of the thigh, at the same time abducting forcibly, and pressing the trochanter inward with the other hand. The reduction usually takes place in a young child with a palpable shock as the head slips in. It is there retained by placing the limb in a position of extreme abduction, carried slightly behind the plane of the body, and fixed by a spica plaster-of-Paris bandage, which extends from just above the knee to just above the iliac crests. This dressing is allowed to remain in place for four or five months, during

which time the child should be encouraged to walk and move about, with the sole of the shoe on the affected side raised two or three inches.

Next comes a procedure in which great skill is necessary, *i.e.*, correction of the extreme posture, and the securing of one of moderate abduction and slight flexion. The danger is of a relaxation, not backward, but forward and upward. The patient should make as much of the correction as possible, assisted by the hand of the operator, and another spica similar to the first is then applied, and left on for five or six months longer.

In double luxations the joints may be replaced at the same time or separately. In case of failure with the bloodless method the next step is, (2) the open operation with slitting of the capsule, or (3) the open method with opening of the capsule and deepening of the acetabulum. Preliminary tenotomy of the short or long muscles, especially the adductors, may be necessary. This is done some weeks before the operation, and is followed by systematic daily extension in bed. The incision is either from the anterior superior spine of the ilium downward and backward along the outer border of the tensor vaginæ femoris (Lorenz), or from the trochanter major directly downward (Hoffa), and carried down to the capsule, avoiding cutting muscular fibres as much as possible. The capsule is split longitudinally and the finger introduced into the joint and constricting bands felt for. These may be cut as encountered, or stretched by the insertion of a dilator (Whitman). By extension and abduction of the limbs, counter-extension upon the perineum by means of a sheet, and direct pressure upon the trochanter, the dislocation is reduced, the head slipping into place with a snap. If the operator is not satisfied with the size of the acetabulum, it can be deepened by making use of the third method, using a scoop for this purpose. The great disadvantage of this method is that it requires long, persistent, and very tedious after-treatment. After the operation, the limb is encased in plaster similar to that of the closed method.—*American Medicine*, June 29, 1901.

Gustave A. Van Lennep, M.D.

TINCTURE OF IODINE FOR CORNEAL ULCERS.—H. Friedenwald has employed this treatment in twenty-five cases of dendritic keratitis and marginal ulcer of the cornea, without failure to bring relief and without untoward symptoms.

The application is made in the following manner :

A bit of absorbent cotton is wrapped firmly about a fine wood applicator or toothpick, so as to form a narrow, firm swab. This is dipped into the tincture of iodine, and the excess allowed to drop off.

The eye having been prepared by instilling cocaine and a drop of fluorescein, the ulcerated area is thoroughly scrubbed until a distinct brown discoloration of the tissues is seen. The neighboring epithelium is very much loosened and curls up in all directions.

It is important to touch this, and especially the minute infiltrations seen a millimeter or two away from the main line of ulceration, for usually these infiltrations precede the furrowed ulceration. The only error which is likely to be made is to apply the iodine too cautiously. He has never seen any ill effect from its being used too freely. Since he has become bolder in using it, it is rare that a second application is needed. The application is usually followed by some pain, lasting for a few hours. The eye is bandaged, and an ointment

of boric acid, iodol, or the like, is applied. The bandage can usually be dispensed with after a day or two, though it may be well to use the ointment a few days longer.—*Amer. Jour. of Ophthalmology.*

William Spencer, M.D.

ANÆSTHESIA OF EAR DRUM.—Dr. E. C. Ellett advocates the use of equal parts of cocain, carbolic acid and menthol, which, he says, permits of painless paracentesis. He continues: After cleansing and drying the canal, he applies this mixture with a cotton applicator directly to that portion of the drum which he wishes to incise. In a moment the surface becomes white, and this is convenient in that it becomes easier to confine the incision to anesthetized parts. While he has used it mostly in adults, he has also tried it in children, and in them it is equally successful, if one can allay their fears over the prospect of being cut.

In one woman he did a double paracentesis at one sitting without pain, and later in the progress of the case it became advisable to enlarge the too rapidly closing incision. This was done under the same mixture, and again without pain. He urges upon his colleagues in otology the use of the mixture, with which he is sure they will be pleased.—*Jour. of the Amer. Med. Association.*

William Spencer, M.D.

SYMPTOMS OF ARTHRITISM IN CHILDREN.—Prof. Comby states that that condition which we call the arthritic diathesis may date back from the very early years of childhood and often is misunderstood. He points out the importance of three syndromes:

1. *Periodic Headache* is a manifestation of arthritism, which symptom is frequently laid to rapid growth, excess of study, etc., and is most frequently observed from the seventh to the fifteenth year. Though periodic it differs from megrim by its greater duration and the absence of nausea and vomiting. At times the headache is so severe as to lead one to think of meningitis, but the history of the case usually clears that up.

2. *Periodic Vomiting* is another valuable sign of arthritism. A child in good health is suddenly seized with vomiting, fever, prostration. At once one suspects appendicitis, peritonitis or intestinal obstruction, but an examination of the abdomen reveals nothing. The symptoms last five, eight and ten days, and then the patient is apparently well until another crisis follows after some time. In these cases, as well, the arthritic nature of the disease may be recognized and these attacks be prevented by proper hygiene.

3. *Uricæmic Fever* is a species of daily intermittent which resembles malaria. It succeeds a cold or comes on without any apparent cause; lasts five, six and eight days, and disappears to reappear in five or six months. Analysis of the urine often reveals an excess of urea and uric acid, while arthritism is found among the hereditary antecedents. In one of his patients the writer has seen a case of this fever end in an attack of gout.

This view of these three syndromes is justified by analysis of the urine, the history and the effect of treatment. As to treatment, but little can be done during the attack. At most one may prescribe plenty of water to drink, tepid baths, enemata, and if necessary injections hypodermatically of artificial serum. During the intervals get the child into the open air as much as possible, send him to the mountains or the sea-shore, give him plenty of exercise, employ hydrotherapeutics, massage, prescribe alkaline, arsenical

chlorated soda mineral waters, either hot or cold, or sulphur waters. The diet should be largely vegetable; all dietetic excesses as well as physical and mental fatigue should be avoided. In other words, hygiene of the lungs, digestive tube, brain, muscles and skin.—*La Rivista Critica di Clinica Medica*, No. 6, 1901.—(In such cases it would be well to examine the kidneys and lungs before being too certain of a diagnosis. Chronic renal diseases are not so rare in children as some writers think. I have found errors of refraction and chronic kidney troubles to be the most frequent causes of headaches in children. A fever resembling malaria in a child, particularly if weakly and spindling, would make me take out my stethoscope at once, and above all things examine the bases, sides and back of the chest carefully.)

Frank H. Pritchard, M.D.

THE REMOVAL OF THE FŒTAL HEAD FROM THE UTERINE CAVITY AFTER DECAPITATION.—(Neugebauer).—The writer has collected seventy cases illustrating this formidable accident or complication of labor. The difficulties to be encountered in removing the head are much more formidable than would be thought possible without a study of the cases reported in literature. The chief reason is that these cases are apt to be complicated by a contracted pelvis. Rupture of the uterus and puerperal sepsis are common complications. Manual extraction of the head under ether gives the best results. The use of the forceps is apt to be disappointing and often must be preceded by craniotomy, removal of the brain and the use of the cranioclast. Laparotomy was necessary in one-seventh of the cases to remove the foetal head.—*Centralblatt für Gynäkologie*, No. 8, 1901.

George R. Southwick, M.D.

THE CORSET FOR MOVABLE KIDNEY.—(Gallant).—The symptoms indicating movable kidney are chiefly pains about the ninth dorsal vertebra, with a feeling of fullness or soreness in the flank. The pain is very distressing and remittent. The patient cannot wear a tight corset, or perhaps no corset at all. The pain is brought on by excessive exercise on her feet, and relieved by lying down and drawing up her knees. The passing of a large amount of urine at times is also suggestive as indicating a discharge from a temporary hydronephrosis. Symptoms of dyspepsia, epigastric pain and flatulence are not uncommon. The writer earnestly recommends the use of the corset in the great majority of cases in preference to operation. He summarizes his paper as follows:

For routine examination the hand is placed just below the hypochondrium and the kidney displaced by deep inspiration, held and palpated, and allowed to escape during expiration. In some cases for the bimanual examination the dorsal or the upright inclined posture will prove more satisfactory. Some of these cases require operation, but 90–95 per cent. can be cured symptomatically by wearing a corset. A corset must be secured as long in front as can be worn, to elevate and support the redundant lower abdominal wall, and form at the waist line a shelf on which the kidney may rest. The best results, symptomatic and modish, are secured when the corset is “made to order,” but the so-called “straight-front” corset, now on sale in every shop, has given very good results.

The corset must be not less than two inches smaller than formerly worn, laced at the back, from the top and bottom, with two flat laces, as an open V,

to prevent chafing and cutting in thin women, and must be laced very snugly from the lowest point to the waist line, loosely from the waist upward, while the patient is standing.

Having thrown the corset around the waist, she lies down on the bed, draws up the knees, places the head upon a pillow to relax the abdomen and permit the viscera to gravitate upward toward the diaphragm, and while in this position fastens the corset. Before hooking the corset she must push the kidney into its nest under the edge of the ribs—a very simple matter when once learned. The lowest hook of the corset must be fastened first, and so on from below upward. As each succeeding hook is secured the redundant abdominal wall must be drawn within the corset. Any woman a victim of nephroptosis must never be permitted to maintain the upright position without having her corset on. A corset fitted and applied in this way will maintain a replaceable kidney in a position from which it cannot be dislodged downward, and will afford relief from all symptoms depending on it.—*Am. Jour. of Obstetrics*, July, 1901.

George R. Southwick, M.D.

HÆMORRHAGE FROM THE ENDOMETRIUM IN SCLEROSIS OF THE UTERINE ARTERIES.—(Simmonds.)—Menorrhagia is often associated with advanced changes in the blood-vessels. With the extreme narrowing of the lumen of the arteries and a diminution of cardiac force hæmorrhages are prone to occur. Pain during the climacteric, as a result of congestion of the uterus, may also be due to great rigidity of the blood-vessels. Arteriosclerosis in elderly women should be thought of as a cause of obstinate hæmorrhage. Removal of the uterus may become necessary.—*Centralblatt für Gynakologie*, No. 39, 1901.

George R. Southwick, M.D.

LEUCORRHEA.—(Burtenshaw.)—The writer states that leucorrhœa is usually checked by toning up the vaginal and uterine mucosa by the plain hot-water douche, and adding to the last quart of hot water in the douche-bag one tablespoonful of the following mixture:

R. Powdered alum,	}Each one ounce.
Zinc sulphate,		
Sodium bichlorate,		
Carbolic acid,		
Water.....		Six ounces.

Hot water increases the absorptive power of the mucous membrane, and may render the frequent use of some of the stronger antiseptics dangerous.—*American Gynecological and Obstetrical Journal*, June, 1901.

George R. Southwick, M.D.

PROTARGOL IN THE TREATMENT OF METRITIS.—(Cailleux.)—The writer has found this remedy very useful for endometritis as well as metritis. The cervical canal is first dilated with Hegar's dilators, the uterine cavity wiped dry with cotton and a few drops of a 10 per cent. to 20 per cent. solution of protargol is applied with a syringe. This treatment is given daily at first, and then every other day. Fifteen to twenty-one days are required. This treatment is not recommended for puerperal or hæmorrhagic endometritis.—*Idid.*

George R. Southwick, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

A REMARKABLE CURE WITH TUBERCULIN.—Dr. Mau, of Kiel, writes "Concerning Tuberculin," in the *Leipziger Populäre Zeitschrift für Homöopathie*, and mentions, among others, a case of idiocy and cretinism that came into his hands after the most prominent authorities in London, Paris and Vienna had been consulted without the slightest result. [Strange these men should apparently know nothing of thyroid extract.] Nevertheless, Dr. Mau was not dismayed. He tackled the case and cured it. The history is the following: Girl, 10 years old; was healthy until 1½ years old, when she was vaccinated, after which it appeared "as if she had no sense" (*als habe sie keinen Verstand*), and her condition grew rapidly worse. She was slenderly built; 2 ft. 5 in. tall; teeth still embedded in the gums; hardly able to stand; not able to walk or talk; forehead low; occipital region prominent; on the cranium various smaller and larger, partly soft, partly hard elevations [nodules]; nose and lips thick. He gave *tuberculin*. Why? On account of the tubercles present. [We cannot quite comprehend what the doctor understands by "tubercle." Probably anything that is roundish and hard, as another case cited seems to indicate.]

Two months after the prescription there was pronounced improvement. She began to talk and walk; the teeth appeared, and the head assumed a more natural shape.

Now, one year from commencement of the treatment with tuberculin, 200th potency, the patient speaks and walks; has grown 3½ inches; the senses are normal, and she is happy that she is alive ("*frent sich ihres Daseins*"). Dr. Mau asks: "Am I right when I say the cause of the idiocy and cretinism in this case was the tubercles which were either acquired through vaccination or inherited from the parents?"

We do not endeavor to answer this question, but we must admit that the result of the treatment was gratifying, if not remarkable. Unfortunately for clinical medicine, but fortunately for mankind, sporadic cretinism is rare, and although thyroid extract is considered a specific, still you may be at a loss some day and be glad to try tuberculin.

Here's another case. *Acute Consumption Cured with Tuberculin*. A gentleman of 24 years was told to go south for his health, but instead he came to Dr. Mau, who felt he could cure him right at home. His neck was full of tubercles [again the tubercle] and he had a fever since months. In the last weeks he had expectorated masses of pus and blood. The breathing was difficult. Two sisters died of tuberculosis. On account of the acuteness of the symptoms, *tuberculin* was administered in the thousandth potency. In several months he was much improved, but had a relapse, which yielded to the same remedy, and since then he is in good health.

Now we do not cite this case to illustrate the curative value of tuberculin 1000th in acute tuberculosis, as Dr. Mau claims. In the first place he has not convinced us that his patient had tuberculosis, and in the second place the history extends over months, and the case was not closely watched. It however recalls to our mind Dr. Cortier's indications for tuberculosis, namely, non-tuberculous bronchitis with profuse muco-purulent secretion and oppression of breathing. The dyspnoea results from the excessive secretion in the bronchi, which also causes general ill-health and emaciation. Physical signs, excepting those of bronchitis, were absent, and as the doctor calls no attention to any being present in his patient, it is just to infer that there were none.

C. Sigmund Raue, M.D.

AN IMPORTANT FACTOR INFLUENCING THE COURSE AND TREATMENT OF PNEUMONIA.—Dr. Mossa cites a case of pneumonia in the *Allg. Hom. Zeitung* (July 4, 1901), beginning as a bronchitis, as a great number of cases of pneumonia develop, under the influence of influenza. The course is more prolonged, less typical, and more profound, usually, than the typical pneumonia described in the text-books. He cites a case reported by Dr. Jousset (*L'Art Medical*, May, 1901). This case developed likewise from an influenza bronchitis, culminating in consolidation of the left lower lobe. There was considerable pain of a stitching character, and profuse muco-purulent expectoration stained with blood. Resolution was delayed and convalescence protracted.

In Dr. Mossa's case it took four days before he could demonstrate a consolidation, although symptoms pointed to such a condition from the beginning. *Bryonia* seemed indicated, but gave no results. He then tried *cheli-donium*, which likewise was disappointing. There being severe pain in the left temple and sensitiveness of the scalp, dyspnoea and rust-colored sputum, at this time, he tried *ferrum phos.*, 6 trit., which acted better than the foregoing remedies. On the seventh day the temperature fell below normal, but after four days it rose to normal, and convalescence continued undisturbedly.

Dr. Mossa quotes from the report of the meeting of the Société Française d'Hom. held last May, at which a discussion of the prognosis of pneumonia took place. It was the unanimous opinion that pneumonia at the present time is more fatal than it was some years ago, and that even under homœopathic treatment the results are not as brilliant as they were formerly. It was held that this change has set in since the epidemic of influenza in 1890. Not alone is the disease more severe, but it is not as characteristic or as pure in type as before that time. This is an important question, and invites further investigation and discussion.

C. Sigmund Raue, M.D.

BAPTISIA TINCTORIA.—Dr. Frederick Kopp, of Greenwich, N. S. W., has succeeded in developing, during a recent proving of the mother tincture of this drug, some very striking head and throat symptoms. These may be found recorded in the July *Homœopathic World*. The author offers some therapeutic deductions that are quite valuable. The *Baptisia* is indicated in the drowsiness and stupefaction peculiar to typhoid fever. It is strictly homœopathic to the "wild" feeling so common in this disease, and also to that peculiar headache which always precedes it. In headaches generally affecting the occiput it is a prime remedy, especially if the pain is accompanied

by great heaviness of the head, sharp pains over the eyes, and a dull, confused, stupid feeling all over the head. In catarrhs, accompanied by dull pain at the *root of the nose*, it must be added to our list, as it is a very reliable remedy here. In fevers, baptisia has been used with great success for the *deafness* or dullness of hearing so common. In that complaint known as *stomatitis maternal*, peculiar to feeble women, it cures promptly, especially in those cases marked by offensive breath. This author uses either the mother tincture or a low dilution. (We notice, in the proving above referred to, several peculiar mouth and tongue symptoms which may prove to be of some utility. Thus, "sensation as if tongue had been burned;" "sensation as if tongue had been scraped;" "dryness, smarting and burning in tongue," and many more of a somewhat similar character. Now it is quite common to be consulted by patients past middle life who suffer from such tongue symptoms, and in whom no distinct pathological condition can be determined. We shall be interested in adding this remedy to the *Iris*, *Arum*, *Capsicum* and others which have already proven to be dependable.)

O. S. Haines, M.D.

THE DIFFERENCE BETWEEN THE ACTION OF HIGH AND LOW POTENCIES.
—Dr. Maybelle M. Park says that some physicians claim to be *good homœopaths* because they never use anything lower than the C.M. potencies, but that this is not necessarily a logical conclusion to be drawn from the single premise. Everything in the universe has its use; it only depends upon us to learn what that use is. So every power of the drug from the tincture upwards is useful to one who understands how to use that power. This observer, however, has found by her experience that, with a few exceptions which she mentions, the *high* potencies will give the accurate prescriber more satisfactory results. She claims that the high potencies act more quickly, more permanently and more gently than the low ones. Thus, in an acute case, the high potency may accomplish in a few hours what it would take the lower days to do. In the more acute cases, however, the remedy may have to be repeated every day or oftener. A high potency in a chronic case will act, in curable cases, for two or three months sometimes; while the low potency, if it could reach the case at all, would have to be repeated every day or oftener. It is a matter to be remembered, that the remedy, high or low, should be allowed to act as long as it produces results, and should not be repeated as long as there is improvement. Repetition of the dose sooner breaks in upon the cycle of action of the previous dose, and creates general disorder. When a chronic patient, under treatment with high potencies of deep-acting remedies and antipsorics, is attacked by some acute disease, the acute disturbance may be treated with lower potencies of short-acting remedies, for these latter will not go deep enough to disturb the antipsoric, but will be sufficient to cure the acute trouble. In infants and aged people, the potencies *below* the one thousandth are better than the higher ones. In severe lung ailments, such as threatening phthisis in cases whose history is bad, if the deep-acting antipsorics, such as phosphorus, silica and sulphur, seem indicated, it will be better to begin with low potencies. A very high potency, going as it does to the very centre of vital action, may aggravate, and the patient will go more rapidly into a decline and die.—*Hahnemannian Advocate*.

O. S. Haines, M.D.

A SERIOUS CASE OF PURPURA HÆMORRHAGICA—CURATIVE EFFECT OF LACHESIS TRIGONOCEPHALUS.—The case of purpura hæmorrhagica reported at length, with interesting comments, by Dr. H. F. Biggar, of Cleveland, was one that should interest every homœopathic physician at least. The patient, aged 75 years, was a vigorous man, free from inherited or acquired disease, wealthy, a hard-worked man in earlier life, but of later years leading a life of ease and enjoyment. As might be expected, he occasionally suffered from gouty attacks. During January of this year he had an attack of la grippe, which ended in bronchial pneumonia. A few days after his recovery from the latter complication there followed acute gastritis and then catarrhal appendicitis. Three weeks after this last attack of sickness he had an attack of gout, complicated by inflammatory rheumatism. It was during the severity of the rheumatic attack that the signs of purpura hæmorrhagica began to develop—first upon his genitals, then the thighs, then the body, face, forehead, scalp, eyelids, then upon the mucous membranes of the mouth, tongue, larynx, nose and throat. The spots were at first quite small. Within thirty-six hours some were as large as a silver dollar, and they had changed from bright red to purple. Then they became reddish-brown, and finally black. Those on the chest and forehead coalesced, the former covering a space as large as two hands, and the latter the entire forehead. The tongue and throat were so swollen and ulcerated that even breathing was accompanied by such distress that tracheotomy was contemplated. It was almost impossible for the patient to swallow even milk. A myocarditic complication made the physicians in attendance very anxious, and they were in constant attendance for twenty-three days and nights. Now what do you suppose Dr. Biggar did under these trying circumstances? *He studied the symptoms of the case carefully*, and he found the homœopathic similimum. For a time he was in doubt whether to give crotalus or sulphuric acid or *lachesis*, but he finally selected the latter remedy; and, in his article, he takes the trouble to tell his readers that he selected the *lachesis* because: "The patient's skin was cold and clammy. Great thirst, and yellow, dirt-coated and swollen tongue. Papillæ enlarged and saliva abundant and very tenacious. Short breath. A patch on the chest as large as a hand, which became bluish. Excessive prostration. Burning of the palms and soles. Bullæ dark from bloody serum within. Fauces swollen and ulcerated." Then he called in a consultant, who wisely advised the continuance of the remedy chosen so carefully. This patient recovered. It won't do to say that the man had "an iron constitution," or that his recovery was a coincidence—for even the nurses and relatives observed his prompt response to the *lachesis*, and marvelled at it. During the convalescence of this patient, his doctor remarked that he was threatened with sepsis from the absorption of the pus confined under the tough crust of the large patch upon the chest. Afterwards the skin became gangrenous and sloughed, leaving a deep ulcer ten inches long, six inches wide; and this healed. Arsenicum contributed to the healing process in the latter stage of the case. This case is reported with commendable thoroughness, and should warm the hearts and strengthen the faith of all good homœopaths. Let's have a few more, brethren.—*American Homœopathist*, July 15, 1901.

O. S. Haines, M.D.

PHELLANDRIUM AQUATICUM—ITS USEFULNESS IN CONSUMPTION.—Dr. Hegewald, of Meiningen, prescribed a homœopathic potency of *Phellandrium* for Mrs. P., who was said to be suffering from *incurable* consumption, and

whose death was shortly expected. She was also advised to use as a beverage a tea made from this plant. The lady did not reappear before Dr. Hegewald for five months. He was amazed at the improvement that had taken place in her condition. We can hardly draw any conclusions from this case further than that the lady was apparently helped by *Phellandrium*. Whether she *had* consumption, or whether her lungs were normal after five months' use of the remedy, cannot be determined. No data of a physical examination are mentioned in the report. This is regrettable.

A young man, G. S., a cyclist, and also a cornetist, had run down so much that he was the very image of a consumptive. This patient was examined physically; and while the physical signs are not given, yet the author says "There was no doubt about the correctness of this diagnosis." Two persons helped him into Dr. Hegewald's office on his first visit, and he arrived out of breath. *Phellandrium* restored this man to health. This remedy was supplemented with *Iodium* and *Aurum foliatum*, however. The author believes that this remedy should prove to be very useful in bronchitis, emphysema, and in phthisis pulmonalis. That it is especially indicated when the *sputa of the patients are exceedingly malodorous as well as abundant*, has been confirmed by Dr. Chargé. This remedy is one of those deserving an exhaustive re-proving.—*Leipziger Pop. F. d. Hom.* Translation in *Homœopathic Recorder* for July 15, 1901.

O. S. Haines, M.D.

MERCURIUS IN PROSOPALGIA.—Dr. W. A. Burr relates a case illustrative of the prompt action of this remedy in a very painful affection. A single woman, aged 22 years, tall and slender, had suffered from severe prosopalgia (left side) for several days. On the night in question she grew worse after becoming warm in bed, and when her pain had increased to an unbearable degree, she sought the doctor. He took the trouble to ascertain her more prominent symptoms, and found, upon inquiry, that there was an aggravation of the pain *at night*, also from *the heat of the bed*; and on going to bed the pains *increased* so that sleep became impossible.

The administration of *Merc. solb.* 3x relieved the pain promptly, and in a very short time she was cured of her prosopalgia.—*The Critique*.

O. S. Haines, M.D.

EUPHORBIIUM.—The resinous exudation of the *Euphorbia resinifera*, exported from Morocco, from which we make our tincture. This remedy is one which must, at least occasionally, be very useful, if indeed it is not indispensable, to the careful prescriber. It certainly is a remedy which will follow Arsenicum. It may be occasionally *the* similimum where Arsenicum or Anthracin have been given preference. As Dr. H. C. Allen has said (*Medical Advance*), the factor in *Euphorbium* that has not been fully developed in the provings, nor brought out in the clinic, is *the terrible burning pain. Intense burning pain, as if a live coal were on or in the part.*

Thus it becomes apparent that this remedy might be useful to one in any of the following conditions: In the *burning* of uterine or mammary cancers; in the bones; in caries or necrosis; in erysipelas, when, too, the vesicles, as large as peas, are filled with yellow fluid; in carbuncle; in the gangrene of old people; in old, torpid, indolent ulcers, with lancinating, biting, lacerating pains, worse in the morning, on becoming *heated* near the fire, on beginning to move, when sitting and from touch; better from continued motion

and from walking. Here is a case that will probably receive either Rhus or Arsenicum. Yet it is probable that Euphorbium will accomplish much more than either of these remedies.

O. S. Haines, M.D.

THE HOMŒOPATHICITY OF CARBO VEGETABILIS TO MANY CASES OF WHOOPING-COUGH.—Few homœopaths ever study this remedy when searching for the genus epidemicus of whooping-cough. On the other hand, Bell., Drosera, Coccus cacti, Cuprum, Kali and Ipecac. are at once the remedies referred to. And yet there is really a long list of significant cough symptoms to be found in the pathogenesis of *Carbo veg.* It is a typical remedy with which to *begin* the treatment of whooping-cough in an otherwise healthy person. It is a good remedy with which to *begin* treatment in those cases in which the symptoms are mainly *objective*, as is so often the case in the affection under consideration. Alone, it frequently is sufficient to eradicate the disease. The following symptoms are especially suggestive of its applicability:

Cough.—Caused by itching in the larynx, in the evening on going to sleep and in the morning upon waking (with viscid, salty sputa).

Cough.—Half-involuntary, from roughness and crawling in the throat; spasmodic, hollow; in short, hard paroxysms, caused by sensation of vapor of sulphur. The cough is mostly hard and dry, or hard and rough sounding. Most apt to occur after a full meal, and ends in vomiting.

Cough.—In three or four paroxysms daily; every coughing-spell either brings up a lump of mucus, which relieves, or is followed by retching, gagging and waterbrash; continuous mucous expectoration, or gagging and vomiting of mucus; great exhaustion after every coughing-spell; blueness of the skin; better from hard fanning; cough and vomiting after all other symptoms of whooping-cough have disappeared; pain in chest after coughing; soreness and rawness, like glowing coals of fire.—H. C. Allen, M.D., in *Medical Advance* for April.

O. S. Haines, M.D.

PSORINUM.—From many years' study and use of this remedy, Dr. Allen thinks that it should justly take the rank of "King of Antipsorics." It becomes the succedaneous remedy when Sulphur fails to act when given for the chronic effects of suppressed eruptions. Likewise when the best selected remedy fails to relieve or permanently improve a patient. Dr. Allen, in his article upon *Psorinum*, in the *Medical Advance*, speaks of this remedy as one likely to be of great service to the homœopathist under any of the following conditions. As these latter are such as we commonly contend with, his article deserves thoughtful consideration. A tendency to quinsy at the change of the seasons. The patient has had typhoid fever or a continued fever years back, from which he has never fully recovered; never sick before it, but *always ailing since*. Hay asthma or hay fever; appearing regularly each year at the same time, even on the same day of the month.

Body has a filthy odor even after bathing. All excretions have a carrion-like odor. Want of vital reaction after an acute disease; tongue is clean, but patient is weak, and the appetite will not return.

General debility and weakness without any apparent cause, or any organic lesion. Severe ailments from slight exertion or from trifling emotions, without any apparent cause; joints easily sprained or injured.

O. S. Haines, M.D.

THE HAHNEMANNIAN MONTHLY.

OCTOBER, 1901.

THE TREATMENT OF ACUTE OTITIS MEDIA.

BY CHARLES M. THOMAS, M.D., PHILADELPHIA.

IN the past winter and spring months, during which there appears to have been an unusual number of acute ear inflammations, I was more than ever impressed by the feeling that the general practitioner bears too lightly his sense of responsibility in the treatment of suppurative inflammations of the middle ear. Earaches, even severe cases, and otorrhœas appear to cause the general run of physicians but little anxiety. While I am not prepared to accept the statement of MacEwan, who says, "I would sooner have a charge of dynamite in my ear than a drop of pus," it is still very certain that many cases of progressive deafness, chronic discharge, and dangerous extension of inflammations to mastoid and brain are the result of neglected or improper treatment of acute otitis media. Not only am I convinced that the physician should more fully realize the risks incident to improperly treated cases of this class, but he should himself be better prepared to carry out the steps of treatment; indeed, that this is so often not the case is remarkable, when one considers how comparatively simple is the diagnosis and treatment of these affections.

I am inclined to think that an inexcusable lack of familiarity in the employment of the head-mirror and speculum is the principal reason for this apparent neglect. I venture to use the word "inexcusable" since, with very little practice, the

ordinary meatus and membrana tympani can be as readily inspected as can the faucial and nasal spaces, yet few physicians would think of treating diseases of these parts without ocular examination; and, as a matter of fact, the diagnosis and successful treatment of inflammatory ear-diseases is fully as much, if not more, dependent upon inspection of the parts as the affections of the regions mentioned.

The great majority of *earaches*, especially in children, indicate an acute catarrhal or purulent inflammation of the drum. As the cause has comparatively little bearing on the management of an acute attack, I shall consider only the questions of diagnosis and treatment; but an additional word as to the subjective symptoms of otitis media may not be amiss. Usually the first complaint is of a stopped-up feeling in the ear, with a pricking, itching or tearing sensation, followed very shortly by sharp pain; or pain may be the very first symptom, and is occasionally, in the distinctive suppurative forms, preceded by a chill.

The suffering is commonly exceedingly acute, often unbearable, and radiates to the side of the throat, the occiput, the mastoid and the teeth; it is increased by exertion of any sort, excitement, swallowing, and coughing. Fever is rarely absent, often reaches 104° , and is almost always associated with great restlessness and sleeplessness. Deafness is more or less pronounced, accompanied by complaint of subjective noises of various sorts, roaring, hissing, hammering, etc. Vertigo is often present. When with small children there are found in addition to these symptoms vomiting, throwing of the head, unconsciousness and convulsions, delirium and irregular pulse, the resemblance to a meningitis may be startling, and, in fact, if the indications outside the drum head are alone depended upon a differentiation may be difficult, and it is in just these cases that the great value of the mirror and speculum becomes apparent.

To be sure it may be impossible in the very early stages, even with the speculum, to distinguish simple inflammation of the membrana tympani, catarrhal otitis and otitis purulenta, but for all practical purposes this is not necessary.

The objective signs, confined as they are mainly to the membrana and its immediate region, can only be made out by the

use of the ear speculum. In the beginning of the attack there appears a moderate injection, particularly along the line of the hammer handle, which rapidly increases until the whole surface of the drum-head assumes a diffuse red hue, with loss of its normal lustre. With the increase in the inflammation the membrane becomes infiltrated and thickened, and, from pressure of free exudate in the drum cavity, loses its concavity, and even bulges forward, particularly in the posterior half. The color now commonly becomes a dull, sodden, yellowish-pink or grey, and the outline of the hammer is lost. A pustule or blebs will sometimes be seen on the most prominent part of the swelling. At the height of the inflammation, *particularly in suppurative cases of the attic*, the upper posterior wall of the canal may become decidedly red, and merge into the membrane so as to obscure its margin, making it difficult to exactly outline it.

Rupture of the drum-head and more or less complete evacuation of the exudate will take place ordinarily in three or four days, though the time may vary, depending upon the acuteness of the attack and the density of the parts, from a few hours to two or three weeks; and in some cases, particularly those of a catarrhal form, prompt recovery by absorption of the exudate, *without perforation*, may take place. Spontaneous perforation may occur at any point, more frequently in the lower half when the case has been one of the catarrhal or muco-purulent form, and in the upper posterior portion in the typical purulent or necrotic cases, which more usually involve the attic. The size of the perforation also varies greatly from that of a pin point to total destruction of the membrane.

When, owing to the amount of discharge, there is uncertainty as to whether perforation has occurred, the appearance of a pulsating point of light at the bottom of the canal, as described by Wilde, may be taken as pathognomonic of its presence. With rupture, there is usually prompt alleviation of the distressing symptoms, and this relief will be permanent unless the size of the opening be insufficient for drainage, or there be re-infection from lack of cleanliness, or reinvasion of micro-organisms by the Eustachian tube (scarlatina, diphtheria, etc.), or some of the outlying parts have already become involved (mastoid, venous sinus, etc.). Cessation of the discharge, clo-

sure of the perforation and restoration of function varies greatly, even in favorable cases—from a few days to several weeks, depending upon the severity of the attack, extent of destruction and completeness of drainage. Usually those cases run the shortest course in which perforation has occurred or an artificial opening has been made early, and in a situation favorable to ready exit for discharges.

The treatment should consist in :

First, an attempt to abort the attack and prevent perforation of membrana tympani or the necessity for an artificial opening. Secondly, this failing, the establishment of thorough drainage through the drum-head. Thirdly, after cessation of discharge, the restoration of function.

If one hopes to abort an attack, *absolute rest and freedom from pain and excitement* are the most important factors to be secured. Aconite, belladonna or ferrum phos. will be found most frequently indicated, and should be given every ten minutes. Hot applications should be made to the ear and side of the head, and this is best done by filling and emptying the external canal with hot (100° to 120°) saturated boric acid solution or bichloride of mercury (1 to 5000); the pinna and the side of head being covered with dry hot flannel, hot-water bag, or the like. With some young children the instillation into the canal will cause much struggling and excitement, and on that account should be omitted. At times a hot *10 per cent.* solution of cocaine appears to control the pain promptly, as does also carbolic-glycerine in the same strength; but this result is not constant. Whatever liquid is used for instillation, I believe it is most important that it contain some form of antiseptic in anticipation of a rupture, or the possibility of having to open the drum-head later, in which case the canal should be, as nearly as possible, surgically clean. The various oily preparations that are often advised I believe are of little use, and may cause harm by infecting the parts through decomposition. When the catarrhal symptoms of the nose or naso-pharynx are prominent, a spray through the nostrils of warm Dobell or physiological salt solution may be useful, but, as a routine practice, I do not advocate it.

If the symptomatic remedy, heat, and local anæsthetics do not promptly quiet the pain and restlessness, I believe it a

matter of much importance that the patient be given a sufficient amount of morphia to secure him fair comfort, and perhaps sleep, for a few hours. If, however, as the effect of the anodyne passes off, it is found that the pain returns or persists, all efforts to abort should be abandoned and the second stage of the treatment instituted, namely, the opening of the drum-head and establishment of free drainage. *The acuter the attack and the more severe the suffering and prostration, the earlier should this operation be done.* Paracentesis, as ordinarily understood and practiced, that is, a simple puncture of the membrane, is, I believe, not only often insufficient, but at times harmful, in that, while it will for a time relieve the suffering, it does not insure sufficient drainage, and, usually closing within twenty-four hours, is followed by a repetition of the symptoms and the necessity for repeating the puncture. A *free division* of the membrane, while just as harmless as a puncture, is far more effective, as it relieves vascular tension by the free bleeding, secures complete and immediate emptying of the tympanic cavity, and provides for drainage for a sufficient time to insure a clean healing. On the other hand, too early incision is to be deprecated on account of the unnecessary risk of infecting the tympanic cavity.

While the general symptoms of the patient furnish a fairly good indication for the operation, the appearance of the drum-head is a more reliable guide. A bulging membrane, especially when the surface is dull and sodden, and particularly when the upper part of the meatal wall at the level of the membrana tympani seems swollen, calls for free incision; but, on the other hand, even when the complaints of the patient are pronounced, if the membrane, though hyperæmic, is bright and not bulging, or is perhaps depressed, one would be quite justified in continuing symptomatic and palliative treatment in hope of avoiding the operation.

Paracentesis, though quickly done, is, for the moment, exquisitely painful, and I think, in a majority of cases, and almost invariably with children, requires a general anæsthetic. At times, when the epithelium has been cast off from the drum-head surface or can be removed by gentle rubbing, the pain of the operation is much lessened by applying, for fifteen to thirty minutes, a solution of 10–20 per cent. of cocaine in hot water.

Antiseptic precautions are, of course, required, and may be carried out by various methods at the fancy of the operator. I prefer to first wipe the whole canal and drum-head with fresh H_2O_2 , and follow this, after gently drying, by an irrigation with bichloride (1-5000) or a light insufflation with impalpable powder of boric acid. These steps are all carried out with the aid of the head-mirror and speculum. The only other instrument required is a narrow knife; and while special myringotoms have been devised for this operation, I can see no advantage in them over an ordinary *small, straight tenotomy knife*; the requisites being an instrument with a narrow short blade and long and delicate shank, which will not obscure the view of membrane by crowding the meatus. The knife before us should be perfectly clean, and, if possible, be boiled in a weak soda solution, or at least well rubbed with sterile gauze or cotton, and immersed for a few minutes in alcohol or a carbolic solution (1-20).

As to the location and form of incision, if inspection shows by the bulging of the lower and posterior segment of membrane that the tympanum proper is the principal seat of the inflammation, the knife should be introduced, edge down, above the most prominent part of the swelling, pressed well into the drum cavity, and made to cut its way down and back to the lower attachment of membrane, and then a little forward, in order to form an opening that will gape more freely than a simple straight cut. If the severity of the symptoms and the localization of the swelling and hyperæmia indicate the graver attic inflammation, the knife should be entered flat, with cutting-edge posteriorly in or below the most prominent part of the swelling, and be pushed deeply inward and upward till it comes in contact with bony structure; a cut is then made back to the posterior insertion of the membrane and then upward, still in contact with the bone, dividing the tissues for at least a quarter of an inch along the upper wall of the canal, thus forming a triangular or tongue-like flap close to the opening into the antrum, and one which will remain patulous for a considerable time. When there appears a general involvement of both the tympanum and attic, I do not hesitate to combine the two incisions, thus opening the membrane from the upper meatal wall to the lower. If spontaneous perforation has already

taken place, it is important to determine by inspection as to whether it is satisfactorily located for ready exit of discharges, and, if not, it should be freely enlarged in the lines mentioned.

Very little is required in the after-treatment if the parts are kept clean and a *free opening for discharge is preserved*. While the so-called "dry" and "wet" treatments have each their strong advocates, I feel that too close adherence to either method, to the exclusion of the other, is ill advised. The irrigation every two or three hours, as recommended by some, I have seen lead to a troublesome excoriation and a sodden condition of the canal and membrane, which much prolongs the healing; and, on the other hand, the packing of the canal with dry gauze is often difficult to carry out with children and in small canals, and particularly where the patient cannot be seen frequently.

Ordinarily I prefer to avoid any interference for some hours after the incision, simply keeping the patient quietly in bed, with the outer meatus lightly filled with a borated or other antiseptic gauze, to be frequently changed should it become soiled. Thereafter, two or three times daily, with a clean glass, or, preferably, soft rubber-ball syringe (which can be kept aseptic by daily boiling), the canal is cleared by a hot saturated boric solution, or bichloride (1-5000). If the discharge is thick, it is highly important to assist its removal from the tympanum—*provided, always, that the opening in the membrane is large*—by gentle Valsalvian or Politzer inflation, or, best of all, by the use of the catheter once or twice daily. The risk of driving discharge by the inflation into the mastoid antrum is certainly trifling, unless the perforation in the drum-head is insufficient in size, and this can be readily determined by inspection.

After the acute symptoms have subsided, I believe it advisable to make use of frequent instillations of some form of astringent antiseptic, both as a preventive of reinfection and to favor rapid healing. I commonly employ either a saturated solution of boric acid in alcohol, 20 to 30 grs. to the oz., or the following modification of the Dolby solution: Zinc sulph., acid carbol., each, grs. 5; aq. destl., alcohol, each, $\frac{1}{2}$ oz.; 8 to 10 drops of either to be poured into the ear, after cleansing two

or three times daily. During the period of discharge the ordinary catarrhal remedies will be called for internally, *e.g.*, puls., hepar, merc., hydras., kali bich., etc.

The syringing and instillation should be done less and less frequent as the otorrhœa decreases, and should finally give place to a daily dusting of the canal and membrane with powdered boric acid. After cessation of the discharge and closure of perforation, and in cases where exudation has occurred without rupture of the drum-head, the restoration of hearing will be greatly hastened by gentle, cautious inflation with Politzer bag or catheter every day or two. In fact, no case should be considered as finished without such final attention to the state of hearing.

A STUDY OF DRUG SYMPTOMATOLOGY.

BY E. M. HOWARD, M.D., CAMDEN, N. J.

(Read before the Philadelphia County Homœopathic Medical Society.)

IN an attempt to analyze and subdivide the vast collection of facts found in the Homœopathic Materia Medica, many groupings have been suggested. Among these, that into Primary and Secondary symptoms stands out most prominently and persistently. Hahnemann himself is the originator of such a division. In the *Organon* (page 98, sections 63 and 65) he speaks of primary drug effects which are followed later by other and opposite conditions, which he calls After- or Counter-effects. He states also that it is only the Primary or positive symptoms upon which we are to base a homœopathic prescription. Later, in his writings, we find him giving the name Secondary to these Counter symptoms, but we also find him recording all such in his provings and constantly making use of them as indications for the application of drugs. For instance, he gave *Veratrum* for constipation, *Nux Vom.* for diarrhœa, etc., etc. He has therefore left the whole matter in a tangle which his followers have not yet unravelled.

At the American Institute meeting at Washington last June, Dr. Eldridge C. Price reopened this discussion by a paper entitled "The Primary Physiological Effects of *Digitalis*, their

Application in Cardiac Derangements, and the Therapeutic Principles Involved."

In this paper he says: "As there is no way of producing drug effects save by the introduction of drugs into the living organism, it must be the vital force of the organism that is responsible for their manifestations. Were it not so, and drugs contained an independent morbid force, as has been claimed, physiological drug manifestations could be secured whether vital force were present in the organism or not.

"Secondary effects are simply due to a lack of manifestation of vital force, or rather are evidences of this lack of action. It is the manifestations we must study, not the lack of manifestation, which is only another way of saying that it is the primary drug effects only that are of importance to the practitioner of medicine."

The theory Dr. Price states above is startling and is open to discussion, but the conclusion is in accord with the earlier statements of Hahnemann, but which, as I have shown, were later determined by him to have been an error. When Dr. Price comes to apply his theory to the *Digitalis* records, he reaches the conclusion that the chief use of this drug by all schools is in the range of its secondary effects, and that such relief as is afforded is, therefore, in accordance with other laws than that of homœopathy. He cites authors of both schools to show that they agree in recommending *Digitalis* in cases of heart weakness and cardiac incompetence, irregular intermittent pulse, loss of tension in the arteries and increased fullness in the venous system. These conditions he shows to be the secondary or opposite symptoms to the first or primary results of ordinary medicinal doses.

In conclusion, he says: "From a comparison of these therapeutic indications, with the primary physiological effects of the drug, it is obvious that both schools prescribe *Digitalis* in accordance with the antipathic relationship in cardiac derangements."

While I cannot accept these conclusions, I am glad that Dr. Price has thus ably reopened this discussion. It will be well if the exact status of the *Digitalis* symptomatology and therapeutics can be established. If he has successfully done so, it will serve as a model on which to work out similar subdivisions for other drugs and establish their therapeutic status.

There are, however, many reasons why it seems impossible to classify successfully our symptoms into primary and secondary. We are confronted at the outset with the impossibility of agreeing upon a definition of what is meant by primary and secondary drug effects. Dr. Carroll Dunham (*Science of Therapeutics*) has pointed out three possible interpretations of the idea primary, based upon considerations of, first, time; second, opposition in character; third, relative rank; as follows:

“First, symptoms may be primary as being earliest in the order of occurrence, as compared with others occurring at a later period.” If time is the element, what shall determine the length of period and where shall we draw the line?

“Second, symptoms may be primary as being in a sense the exciting cause of other and opposing symptoms, which are secondary to, as being contingent upon, the former.” We will discuss the difficulties of drawing this distinction later, but call attention now to the fact that this cannot be applied to all drugs, as many symptoms have no opposites.

“Third, symptoms may be primary, as being of greater importance than others which may thus be called secondary to them.”

This being a relative matter cannot, of course, be used as a dividing-line. Dunham says that Hahnemann combined the first two of these in his idea, that of priority of time with that of opposition in nature.

Hahnemann considered the opposing symptoms to be reaction effects of the vital force, reaction to the drug effects produced initially and not due to the drug at all. And yet he records them carefully in all his provings, and, thus mixed with the others, they have come down to us as an evidence that Hahnemann had not solved the question to his own satisfaction.

Prof. Dudley has recently made the following definition: “Primary symptoms are the result of the drug’s action on that part of the body for which the drug has an especial affinity. Secondary action is that induced by the primary disturbance and not by the drug. Both of these conditions producing counter symptoms.”

It is difficult to harmonize these different definitions, although each represents a phase of truth, and hence it seems impossible to satisfactorily classify our symptomatology on any of these lines.

With these difficulties in view, let us study other subdivisions of symptoms and see if they will help solve some of these problems.

For this study I offer the following :

Local.....	{	Mechanical.
	{	Physiological.
Remote. {	Direct	Physiological.
	Indirect....	{ Physiological.
		{ Mechanical.

All drug effects may be divided into two groups, according to whether they are local or remote. That is, all drug manifestations must be shown either at the first point of their physical contact, or at some point remote from that point of physical contact. This is a clear-cut division except for those drugs administered by the mouth. Such drugs for all practical purposes must be considered to be outside the body so long as they remain outside the circulation. So that their point of physical contact may be anywhere throughout the entire alimentary canal. All effects so produced must be considered Local. When once taken up by the circulation their effects would be considered Remote. I must, however, leave for future consideration those results produced by the presence of drugs stored up in the tissues of the body, such as mercury in the liver, plumbum in the gums and silver nitrate in the skin, etc., etc.

Now, again, we may safely subdivide these local effects into two groups, Mechanical and Physiological.

The local effect may be such as to destroy tissue entirely, burn it, or change it chemically so as to interfere with function in a purely mechanical manner. Or it may be simply and specifically such as produces functional physiological disturbances, by reason of special affinity to those tissues of the body.

It is evident, however, that only the latter or physiological division of these two can bear any possible relation to the cure of disease, or rightfully belong to a homœopathic symptomatology.

Knowledge of such mechanical effects can be and often is used for chemical or mechanical purposes. It certainly is allowable and often convenient to destroy tissues by caustics instead of using the knife. But the fact that nitric acid will de-

stroy tissue does not make it a homœopathic similar to any form of ulceration; nor does any of the train of symptoms which may result from such loss of tissue, however immediate or remote, have any place in our pathogenesis, or bear any possible relationship to any homœopathic prescription or to any other possible law of cure.

The same may be said of caustic potash or silver nitrate or any other caustic poison, whose mechanical injuries to mucous membranes may result in strictures and contractions, which may ultimately cause death years after the drug has been swallowed. It is not possible to believe that any such resulting effects of local injuries, or symptoms arising therefrom, can ever be a guide to the cure of any form of disease, and they ought to be excluded in the makeup of every homœopathic prescription.

Very different from these symptoms are those cases of ulceration which result from the long-continued disturbances of function caused by such drugs as mercury, kali bichromate, hydrastis, etc., etc. Such drugs do indeed have a local mechanical effect, if used strong enough, but their long-continued use in small doses produces, as remote effects, every grade of inflammation of mucous membranes, beginning with simple increase of mucous secretions and ending with such grave inflammatory conditions as will cause actual ulcerations and bloody exudates. These are true physiological effects. It is perhaps fortunate for the results of homœopathic prescribing that many drugs which produce local corrosive action do also develop similar remote physiological symptoms, so that prescriptions wrongly based on such mechanical effects have not always come to grief.

Remote drug effects also may be divided into two kinds—Direct and Indirect. Direct symptoms are those distinctly traceable to the drug influence, and are the result of the affinity such drug has for the particular part or tissues involved, and such symptoms are always physiological.

Indirect symptoms are those induced by the previous drug disturbance and cannot be attributed directly to the drug used, being such as would be produced by any other influence or drug capable of causing a similar initial disturbance. (See Dr. Dudley's definition of secondary effects.) For example: Opium

taken by the mouth produces constipation as a direct remote effect. As a result of the constipation, hæmorrhoids may develop, an indirect result, inasmuch as any other constipating force might produce the same condition.

Bryonia produces inflammation of serous membranes with characteristic pains and fibrinous effusions. These effusions give rise to mechanical disturbances of the breathing, of the heart, or of locomotion. Such symptoms are certainly indirect results, but as, however, they are purely mechanical in nature, it would seem certain that they also should not be considered in a homœopathic prescription.

We must perceive that such symptoms occupy a very different relationship from such as are called counter or secondary, like the constipation of bryonia or the diarrhœa of opium. The first are purely mechanical disturbances and their results. The second is an instance of continuous physiological process set up by the drug, beginning with inflammation and ending with the natural continuation of the same process until, by exhaustion or inflammatory changes, the actual opposite or counter-symptoms are produced.

We must, therefore, subdivide the indirect drug effects into two—Physiological and Mechanical; and, as we did the local division, exclude the mechanical from therapeutical consideration. For it is evident that there is a vast difference between such true mechanical disturbance of function and real physiological processes which are the natural continuations of initial drug effects, and so may be legitimately attributed to the drug influence. There is a vast difference between the brain symptoms developed by the pressure of too much fluid in the ventricles (purely mechanical) and those conditions of sopor resulting from continued brain congestion, but whose first or primary effect had been cerebral excitement. It seems questionable whether any such mechanical symptoms can ever become keynotes, and I think we ought to exclude them from homœopathic prescriptions.

Now we are prepared to consider the primary and secondary symptoms of *Digitalis* as outlined by Dr. Price. He has shown that the first effect of this drug in ordinary doses is to cause a slow and powerful arterial force. As an immediate result of this continued over-action, the pendulum is sure to swing the

other way, and ultimately there will develop the opposite condition—a worn-out, tired heart, showing rapidity and weakness, with all the concomitant symptoms. Now these are seemingly indirect remote effects, as above outlined. To which subdivision do they belong? To the mechanical or the physiological? We might, perhaps, be inclined to class them as mechanical were it not for the fact that the self-same condition may be produced as a direct effect if a sufficiently large dose be given at one time. There are many other drugs which act in the same way. For example: Aconite, in small doses, has, as its primary effect, unmistakably feverish conditions, but when given in sufficient dosage will produce at once the lowered pulse and temperature which precedes collapse.

It is evident that such symptoms do not belong in the same category as the mechanical results above outlined. We must consider them as simply different stages of one continuous physiological process, and, therefore, the only symptoms we can legitimately exclude from the reign of the homœopathic law are the purely mechanical effects.

The problem is beset with difficulties, because it is impossible to determine the exact status of many of these remote symptoms. There is such an intimate connection between certain organs, as, for instance, between the heart and kidneys, that it is difficult to know which organ is primarily affected, and whether the effect is a direct or an indirect one. But this should not deter us from the effort to solve it.

Regarding the greater part of the counter symptoms, the reaction effects of Hahnemann, and the secondary of Price, I have come to the conclusion that it will be nearer the truth to state that most drug action of this type is one continuous chain, of which each symptom is a link so intimately connected with others preceding and succeeding that it is impossible to separate them. Is not the weak heart of *digitalis* simply the last link in a chain which began with stimulation?

If this should be granted, I would define primary symptoms to be the first or initial influence or disturbance in point of time upon any particular function, tissue or organ.

I would consider all else in the long chain of resulting symptoms as secondary, but I do not see that they partake of any other quality that makes it possible to draw a dividing-line.

If this be true, then we must agree with Dunham that no law

or rule of dosage can be deduced from any division of symptoms into primary or secondary; and yet the whole question of dosage is involved. It is certain that different stages, or kinds and degrees, of symptoms are developed after different medicinal doses. If Hering was right when he asserted that we should prescribe doses analogous to those that produce the grade of symptoms presented by the case under treatment, then it is in accordance with the law of similars to prescribe large doses of digitalis for the weak hearts of threatened collapse, and Dr. Price is wrong in his contention that such dosage is an example of antipathy.

Let us rather compare drug effects, as applied to disease, to a stone rolling down a hill. Its progress is at first slow, and small obstacles will check its speed, but as it gathers momentum it becomes a mighty force, requiring strong agencies to control its energy. So it is true, in the beginnings of disturbances of physiological function, that small doses are eminently successful; but when the case has pushed its physiological disturbance to the last degree, and the patient is on the brink of the grave, we may need powerful agents to stay, if at all, the ravages of the disease.

Chronic diseases present a different state of affairs. No such condition can be produced by single large doses of any drug. Hence, if that equilibrium which we call health is to be re-established, it will be necessary to seek such drugs and use them in such doses as would have the power of originating these conditions which have become so nearly permanent. And so it happens that the smaller doses are more often the ones which, by their long-continued action, will ultimately influence existing conditions.

It is thus demonstrated that symptomatology must be studied in the light of its natural history; that, excluding mechanical effects both local and remote, we dare not draw any other dividing line; but that, finding the tissues and functions for which a drug has its especial affinity, we must trace out its various physiological disturbances from beginning to finish; that every symptom thus appearing, whether local or remote, direct or indirect, primary or secondary, must be classed as a true drug effect, and may be rightfully used, in accordance with the law of similars, as a guide to the selection of the remedy for any disease which presents the same or a similar natural history.

THE DIAGNOSIS AND TREATMENT OF CHRONIC GONORRHŒAL PROSTATITIS.

BY L. T. ASHCRAFT, A.M., M.D., PHILADELPHIA.

(Read before the Interstate Homœopathic Medical Society, Scranton, Pa., November 15, 1900.)

Mr. President and Members of this Society: While in this paper it may become necessary to refer to other varieties of prostatitis, yet my remarks will be confined chiefly to the gonorrhœal types. Indeed, this paper may be regarded as a sequel to "The Diagnosis and Treatment of Acute Gonorrhœal Prostatitis,"* and also as a complement to "Seminal Vesiculitis."†

It is a fact that 90 per cent. of cases of chronic prostatitis may be traced directly to acute specific urethritis. No one should be considered cured of gonorrhœa until the materials expressed from the prostate are examined and found free from gonococci. In chronic gonorrhœal prostatitis the pathological condition almost invariably includes coincident inflammation of the seminal vesicles, the posterior urethra and the epididymis. Chronic gonorrhœal prostatitis is frequently responsible for acute urethral infection and pathological alterations of the ano-rectal region, and principally important because it is now recognized by many as the chief factor in the production of hypertrophy of the prostate and as a potent cause of sexual debility. Clinically, we observe the follicular type involving mostly the glandular structure. A diffuse variety involving connective and muscular tissue, para- and peri-prostatic tissue, the seminal vesicles and the spaces between them, and prostatic, peri-prostatic and occasionally pelvic abscess. Etiologically, both congestion and infection must coexist to produce the condition. Congestion arises from excesses in venery or masturbation. A congenital or acquired defect of the urethra, such as atresia of the meatus, or stricture of large calibre or chronic catarrhal inflammation of the urethra, may produce it by interfering with the volume of urine. Hypertrophy of the prostate, with its consequent strain upon this organ, also favors conges-

* See *Transactions Homœopathic Medical Society State of Penna.*, 1900.† Reprint from the *HAHNEMANNIAN MONTHLY*, April, 1898.

tion. In a similar manner traumatism may invite it, as will irritability of the sphincter ani and other pathological conditions of the ano-rectal tissue. Disease of the bladder or kidney, concentrated urine, and errors in eating and drinking also furnish the elements for congestion. Infection may occur from pyogenic or other organisms transplanted from the urethra during instrumentation, by the bacillus coli, by different organisms found in cystitis and by urinary tuberculosis. The symptoms, varying with the character of infection and the extent of the surface involved, are referable to the uropoietic, sexual and rectal systems. There are, too, certain reflex pains, and in all cases psychical disturbances of varying intensity.

Chronic follicular prostatitis rapidly follows the acute form, producing some disorder of urination, varying, of course, with the extent of the parenchyma involved. Usually, where but few follicles are affected, the condition is but a slight exaggeration of chronic posterior urethritis, urination being unduly frequent both by day and by night. There is usually a degree of pain referred to the fossa navicularis. Too much stress, however, must not be laid upon the location of the pain, since not only in prostatitis, but also in other morbid conditions of the urinary canal, pain is usually referred to this region. Pain is caused by the urine irritating the infected mucosa and from the contraction of the perineal muscles. Not infrequently a little blood may follow urination, suggesting the presence of stone or tuberculosis. Oftener, however, the last urine voided will be milky, due to precipitated phosphates; and, in some cases, a glairy, semi-gelatinous fluid follows the act. If the urine voided be allowed to stand for a few hours, the tube will show a deposit of varying density. A microscopic examination of this deposit will reveal at various times and in different specimens mucus, occasionally pus, sometimes gonococci and tubercle bacilli, usually dead or feeble spermatozoa, and usually granular phosphates, triple phosphates, and, in some instances, crystalline phosphates of lime. Certain urethral symptoms are present. The canal feels as if it were wet or damp; indeed, in some cases inspection of the meatus and stripping of the tube may show a sticky globule, suggesting, perhaps, the chronic, catarrhal discharge associated with stricture of large calibre. In certain advanced cases this gelatinous fluid is so excessive

that the term "prostatorrhœa" has been aptly given to it. The rectum, too, participates in a mild degree; usually there is a sense of fulness and tenesmus. In very pronounced cases hæmorrhoids may be present.

In this connection I wish to speak of pruritus ani as a symptom of this condition. Dr. R. W. Martin assures me that in 25 per cent. of the cases that consult him for this troublesome affection, unmistakable evidences of prostatic involvement exist. During the passage of large stools, pressure upon the prostate causes a flow of glairy fluid from the meatus. Rectal examination reveals areas of tenderness. Very little light is thrown upon the prostate by urethral exploration except where the prostatic urethra is involved, in which event a degree of pain will be present as the sound passes into the bladder. Sexual disturbances, while an occasional feature, are more pronounced when seminal vesiculitis complicates prostatitis. A certain degree of pain referable to the perinæum and anus exists; and in some cases these discomforts are reflected to the supra-pubic region and the thighs. Vague pains are also felt about the testes, epididymis and cord. In the chronic diffuse type, these symptoms are all exaggerated. It is very difficult to differentiate between this and the follicular variety. Indeed, they frequently co-exist, and it must be remembered that in the chronic diffuse type the pathological process embraces the seminal vesicles. The symptoms may be best recognized by quoting verbatim from a previous article, "Seminal Vesiculitis," *HAHNEMANNIAN MONTHLY*, April, 1898:

"The symptoms referred to point directly to interference with the sexual function. In mild cases, sexual erethism is an annoying feature, while feeble erection and lost desire are present in advanced subjects. Coitus, if practiced, lacks pleasure, the ejaculatory act being precipitate or tardy, and sometimes very painful. Seminal losses constitute a very annoying and persistent feature; nightly pollutions are very frequent, even after sexual indulgence. The normal color of the urine is changed to a brown or red shade. This is frequently observed in those cases which are complicated with tuberculosis. The rectal symptoms are more pronounced when the prostate impinges upon the rectal lumen, producing not only uneasiness and fulness, but also in very marked cases hæmorrhoids, and even rec-

tal prolapse. The urinary features are more pronounced in this type, the act being more frequent, more imperative, and more painful. These symptoms are not present in every case; indeed, in the non-gonorrhœal type a condition may exist without presenting any symptoms, while they are all magnified in the tubercular form. The local tissue changes can be appreciated only by urethral and rectal examinations. In advanced cases, some resistance may be offered to the sound or catheter. Surprising as it may seem, I have occasionally observed, even in young men, a small amount of residual urine. It is, however, only by rectal examination that we can appreciate tissue changes. Incidentally, it may be well to mention the technique of rectal exploration.

“The patient, presenting himself with a full bladder, should, while standing with his knees straight, bend the body forward at right angles; then the examiner should introduce the forefinger of one hand well into the rectum, with the fist of the other hand exercising firm counter-pressure over the pubes.” In some cases the prostate will be found engorged and swollen in one or both of its lobes, sometimes very irregularly, suggesting tuberculosis; in others very little, if any, enlargement will be detected. More often, however, a uniform enlargement will be detected. The rectal tissue on either side will be found to participate in the morbid process, as well as that immediately above the organ. When the examining finger is carried well up into the rectum, the vesicles may be recognized as hard, swollen bodies, pressure upon which causes pain and a sense of faintness. Either active or a low grade of suppuration may be a feature of both the follicular and diffuse type, and be the sole means of the continuance of a urethral discharge or a new infection either of the urethra or the bladder, or the starting-point of a peri-prostatic abscess. Not infrequently one or more occluded prostatic ducts rupture and discharge their contents into the interstitial substance of the prostate, causing extensive abscess formation, which may not only destroy the integrity of the organ, but by burrowing communicate with either the bladder or rectum.

In the presence of these symptoms it is not very difficult to recognize one or more of the varieties of chronic gonorrhœal prostatitis. The chronic follicular type must be distinguished

from chronic posterior urethritis. In the latter, rectal examination reveals a limited area of tenderness directly over the prostatic urethra, and the usual two-glass urine test shows chronic posterior catarrh. Microscopic examinations fail to reveal the characteristic urinary features of prostatitis. The chronic follicular type may be distinguished from the chronic diffuse form by the concomitant symptoms of the latter and by rectal examinations revealing a more diffuse and general enlargement, together with pronounced areas of bulging; and, again, in this type we usually have the distinctive features of seminal vesiculitis. It is sometimes difficult, particularly in men well advanced in middle life, to differentiate between chronic, diffuse, gonorrhœal prostatitis, and beginning senile hypertrophy. In the latter, however, there is usually a lack of sexual irritative symptoms and mental and physical disturbances. Again, there is always an increased amount of residual urine. Tuberculosis of the prostate simulates closely chronic, diffuse, gonorrhœal prostatitis; indeed, in some cases it is almost impossible to differentiate except by the detection of tubercle bacilli. From seminal vesiculitis it may be recognized by outlining well above the prostate two hard, swollen bodies. Then, again, in seminal vesiculitis the symptoms are usually referable to some disorder of the sexual apparatus. It must be distinctly borne in mind, however, that the two in the chronic diffuse type usually co-exist. The non-gonorrhœal type of chronic prostatitis is differentiated from the gonorrhœal form by diminution of symptoms and the absence of gonococci. Some exaggerated types of diffuse gonorrhœal prostatitis may be mistaken for cystitis, particularly the calculus variety. The differentiation, however, may be cleared up by an examination of the urine failing to reveal pus in the last glass, or by the sound failing to detect any evidence of stone. In suppurative prostatitis, cystitis is usually present.

While chronic gonorrhœal prostatitis rarely, if ever, results fatally, except by a chronic suppurative process or the formation of an acute abscess rupturing into the surrounding tissues, yet it must never be forgotten that the condition when once established is hard to cure, because of the relationship existing between the prostate and the urethra and the lack of drainage.

Certain therapeutic measures apply to all types. Moderate

sexual indulgence is beneficial, since it relieves prostatic hyperæmia. The urine must be kept bland and unirritating, consequently it will be found necessary to abstain from all articles of food which increase its specific gravity, particularly red meats. Urinary asepsis, too, can best be obtained by the administration of five grains of urotropin after each meal. Moderate exercise, preferably by walking, should be encouraged. Too vigorous exercise aggravates the condition. Overwork of any kind, mental or physical, must be positively interdicted. Patients must avoid taking cold. They must wear flannels during all seasons of the year. The most minute attention must be paid to the bowels; daily evacuations should be encouraged, even at the risk of becoming used to laxatives or enemas, since constipation adds only to discomfort by causing pain during defecation. Neurotic conditions, when present, must receive appropriate treatment. Strychnia, iron, arsenicum, phosphorus, nux vomica and hyoseyamus constitute a group of well-indicated drugs. In highly nervous individuals, bromide of potassium is invaluable; while selenium is always to be considered where the genito-urinary organs are in an atonic condition. For each type there are certain peculiar lines of treatment. Chronic inflammation of the prostatic urethra demands measures that will allay urinary and sexual symptoms. This can be obtained by internal remedies and by pressure with Guyon's posterior dilatator.

A description of this instrument has been given in one of my former articles.* The dilatator is dusted with sufficient talcum powder to enable its sterile rubber cover to slide quite easily, after which the branches of the dilatator are expanded to their limit, which is 47° F. Having confidence in the cover, since, if it breaks within the urethra, the branches of the dilatator might injure the urethral lining, the instrument is anointed with Lubrichondrin and passed very carefully into the bladder. The operator adjusts the instrument at right angles to the patient's body, holding it steadily for half a minute, after which its wheel is slowly and carefully turned until the patient experiences some slight resistance. It should then

* "The Treatment of Hypertrophy of the Prostate." Reprint from the Transactions of the Homœopathic Medical Society, State of Pennsylvania, 1899.

be screwed down about two millimeters and the patient, who has been made comfortable by lying in a semi-recumbent position on an upholstered table, is instructed to hold the dilatator until further orders. The instrument is held in position three minutes, after which its branches are closed and it should be most carefully withdrawn. The bladder should then be irrigated with a 1-4000 solution of permanganate of potassium; otherwise infection and urinary fever might follow. This procedure may be repeated every third day, unless contra-indications, such as fever or frequency of urination, develop. It is my custom to prolong each sitting five minutes, obtaining from two to two and a half millimeters dilatation.

Before directly treating the prostate, certain conditions, if present, must be eradicated. Congenital narrowings of the meatus must be enlarged. Strictures of large calibre situated no deeper than three and a half inches must be divided; beyond this they can usually be dilated. Indeed, chronic urethritis in any portion of the tube must receive the appropriate treatment for its eradication. It is in the follicular as well as in the diffuse type that our most brilliant results are achieved by rectal massage. With this end in view, provided an irritability of the sphincter ani exists, it becomes necessary to resort to rectal divulsion, the indications for which were furnished to me by Dr. R. W. Martin.

"The indications for divulsion of the sphincter ani are found in any irritable condition of that muscle or any lesion of the mucosa in immediate contiguity to the sphincter, except prolapsus from a paretic state, in phlebitis of the hæmorrhoidal plexus or parts of it, or either partial or complete strangulation of the ano-rectal mucosa or inflammations of adjacent organs, as the deep urethra, prostate, peri-anal, peri-rectal and peri-prostatic connective tissues. The results of proper divulsion are relief of strangulated vessels and nerves, restoration of the normal circulation, and relief of pain, since by thorough removal of the venous stasis it renders subsequent local treatment much easier and infinitely less painful. The method that I use is that known as rapid divulsion. I have a record of several thousand cases, in a very small number of which I have found it necessary to repeat the operation. I prefer nitrous oxide anaesthesia, since the patient is rendered unconscious during

the short time necessary to accomplish the divulsion, the sphincter muscle meanwhile retaining in a great measure its resistance and sensitiveness, this aiding materially in guiding to the attainment of the proper degree of force. Under the influence of ether (except in the primary stages) all resistance of the fibres is overcome, and one is liable to do a great deal of mischief by laceration before the feeling of having overcome the abnormal contraction of the muscle is fully realized."

This treatment diminishes pain by allowing room for the growth of the prostate, and also furnishes enough space for rectal examination. I cannot lay too much stress upon the value of ichthyol, locally applied. It is my custom to make an application every three days of a 25 per cent. aqueous solution of ichthyol to the surface of the prostate by means of Martin's rectal speculum. Other speculae do not possess the advantages afforded by his, since in its use the entire prostatic lumen is brought into view.

Massage of the prostate and seminal vesicles is the best therapeutic measure we have at our command. It is beneficial because it reduces congestion by expressing from the diseased organs their morbid products. It stimulates the tissues, increases circulation, and causes an absorption of inflammatory exudate. The technique is the same as that employed for rectal examination of the prostate and vesicles. The index finger, well lubricated, should exert firm pressure on each segment of the gland. It will be noticed, during the milking process, that a not inconsiderable amount of prostatic secretion and product of the seminal vesicles exudes from the meatus. The first seance should last about one minute. Each successive one may be prolonged, until sometimes the milking process may be extended to five minutes. It should be repeated about every four days. More frequent milkings are apt to cause local irritation. The operation is associated with some degree of pain. Indeed, I have several times observed patients becoming faint. Under such circumstances it is well to have the patient lie down upon the table in order to receive treatment. After massage, he should urinate. By this means we may inspect the urine, and thus judge the amount of morbid material that has been expressed. Bladder irrigation should always follow; otherwise acute cystitis may supervene. Immediately following, it is

advisable to administer rectal irrigations of very warm water. The prostate may also be treated by inserting suppositories, each containing five grains of ichthyol and a sufficient amount of cocoa butter; one should be inserted morning and evening. There are some cases, particularly of a chronic diffuse type, in some a combination of all types to which varying degrees of suppuration have been added, that fail to respond to any of these methods of treatment. Under such circumstances I have obtained very good results from perineal drainage. It is beneficial for the following reasons: As the patient is under a general anæsthetic, it affords an opportunity to thoroughly milk the prostate, its appendages and the seminal vesicles, at the same time overstretching the vesical neck. This in a measure relieves some of the urinary symptoms; also, during operations, small abscess cavities may be evacuated. By this means an avenue is afforded for drainage. In chronic suppuration it may be advisable to attempt entire enucleation. I have purposely omitted mentioning cauterization by means of the Bottini cauterizator, since at present I can give no positive statement as to results. Some amelioration, however, followed in each instance. This instrument differs from Bottini's incisor in this point: it possesses no blade, and therefore does not incise; it only sears. During operation, however, the cautery should be passed slowly and carefully twice over the surface of the prostate. For successful work it is necessary to have a storage battery furnishing a current of forty amperes. The operation is best suited to chronic, diffuse prostatitis of middle-aged men. By resorting to such, indeed, we may prevent the formation of marked senile enlargement. It is not particularly indicated in chronic prostatitis associated with a degree of cystitis. Here it is best to combine with perineal drainage. It possesses all of the good features associated with my modification of the Bottini operation.

THE PREFERABLE OPERATION FOR MOVABLE KIDNEY.

BY G. MAXWELL CHRISTINE, M.D., PHILADELPHIA, PA.

(Read before the Surgical and Gynæcological Society of the Am. Inst. of Hom., June, 1901.)

In selecting the preferable operation for movable kidney, the surgeon will always be guided by motives actuated by the highest interests of his patients.

Not only will immediate effects be considered, but remote results will be anticipated by him, and that operation will be chosen which, regardless of preconceived notions or operative habits, gives the best promise of safely and permanently anchoring the kidney in a position where it will be free to functionate, and yet be preserved from harm both to itself and to other parts of the body.

The operation of inducing circumferential plastic or adhesive "inflammation" in the kidney and contiguous tissue is the one this paper will advocate, because it has advantages not believed to be possessed by any other, and apparently has none of the elements of danger or failure frequently observed in operations in vogue prior to the advent of this particular method.

It is not uncommon to have relapses after nephropexy done by the old transfixion and suspension methods; and we are well acquainted with the harm frequently done the kidney, certainly the anxiety occasioned the operator, by sutures through the kidney or its capsule, or both.

The hæmaturia and pyuria often following operations of this kind indicate the traumatism set up in the renal structure; and, as the amount of harm done the kidney is sometimes material, any operation which offers absolute freedom from symptoms of this character makes a strong bid for preference.

Furthermore, when the kidney depends for its fixation on the sutures through its structure, the point of fixation is apt to be limited to an area narrowly circumscribed about the part sutured.

Though this is not the effect altogether sought for in this method of operation, dependence being placed, in addition to the direct union at the line of suture, on plastic union with ad-

joining structures at other portions of the kidney, failure to get union is so often the case as to furnish a plausible excuse for discounting as at least apt to be defective, operations in which sutures are used.

Aside from being untrustworthy as to union, sutures of a permanent character are sooner or later liable to occasion trouble as foreign bodies, and to produce abscesses and fistulæ.

To overcome the objection to sutures through the renal substance, suturing the fibrous capsule and attaching strips of muscle for purpose of support to the capsule, etc., have been adopted; but objections have arisen which make such efforts questionable as to permanency of effect, and awaken a desire on the part of surgeons to obtain as good or better results by a less objectionable and therefore more efficacious method.

I believe it was the elder, and subsequently the younger Senn who, recognizing the defects of all suture operations, whether through renal substance or capsule, first adopted a method of fixation in which advantage was taken of the property possessed by gauze to set up a plastic or adhesive "inflammation" between the surface of the kidney and the surface of the surrounding tissues of the renal pocket.

That this plastic union takes place is as surely the case as that it occurs in any other plastic operation.

It is well understood that within certain limitations it makes very little, if any, difference where the loose kidney is placed and fixed, provided tension and danger of torsion are removed from its pedicle.

Early in the history of nephropexy great effort was spent in fixing the kidney exactly in the locality of its original position.

Manifestly, this was found difficult of consummation, and, as has been determined by experience, entirely unnecessary.

The amount of latitude in mobility it is possible to grant the kidney without apparently encroaching on the functioning properties of the organ is very great, since, in so far as the pedicle and peritoneum are concerned, exposure of the kidney to the outside of the wound after it is freed from its fatty capsule is easily effected.

We know that ordinarily the kidney moves through a space which, in general terms, is measured by the respiratory effort.

It is most probable that nature has provided that this normal

range of movement can be greatly added to without material symptoms.

Certainly, in old chronic movable kidneys which have been excessively prolapsed, and in which, therefore, this range of travel is greatly augmented, the severe symptoms, and generally all the symptoms, can be relieved by appliances made to limit the excursion of the kidney, but which makes no pretence to putting the organ fully back into its normal bed; and often we find kidneys far out of position which are symptomless.

Reasoning, then, from experience, and from our knowledge of the latitude of motion granted the kidney under certain conditions without producing symptoms, we reaffirm that so long as the kidney is fastened to the tissues in which it is imbedded, is put as near as possible in proper relationship with its pedicle, and is prevented from making sudden and unexpected excursions and torsions in the renal pocket, it makes little difference where, in that pocket, the organ is anchored.

This part of the discussion has little to do with the consideration of the subject proper of this paper, except to make it clear that fixation and relationship are the primary results to be secured, while position high up or low down, deep in or well out in the renal pocket, plays only a secondary part in the procedure.

Yet, if position is at all an element of importance, the gauze method has the one virtue of fastening the kidney as deep down in the renal fossa as any operation thus far proposed.

The disadvantages of suspension or fixation by means of suture through the kidney substance are obvious.

Not so objectionable, however, is the method of suturing the partially stripped fibrous capsule to the muscular edges of the wound, relying both upon the suspension furnished by the attached capsule and the plastic union secured at other parts of the kidney surface.

The objection to this operation is that fixation is certain only at the sutured edges of the capsule, while the rest of the surface of the kidney may or may not attach itself to the adjoining structures; and, further, that a portion of the kidney is exposed to possible organic change from the traumatism.

Relapses of cases done by this method suggest that the cap-

sular fixation is none too secure, that it gives way under strain, and that there has been no union at all effected between the kidney and contiguous tissues.

The gauze method removes this objection, and appeals to us as being freer from negative qualities than any of which we know.

The operation is simple, and will suggest itself not only to the profession at large, but as well to the laity, as being free from the possible and almost probable serious results attending the use of sutures through the kidney.

Furthermore, we have no cicatricial contraction in the kidney, more or less extensive and necessarily following the introduction of sutures into its substance.

After the kidney has been exposed through an incision in the loin, perhaps best made obliquely, the muscles not being cut any more than is necessary, but carefully separated, it is brought outside of the wound, and all of the fat removed from the surface.

After all the fat in the wound has likewise been cleared away, two folded strips of iodoform gauze, long enough to envelop the kidney and protrude for several inches out of the wound after the kidney has been restored, are placed around the organ, one above and the other below the median transverse line.

There is no advantage to be gained by making the strips more than four-fold thick.

More than this is likely to be detrimental in making it difficult to restore the kidney to its place, and also in the subsequent removal of the gauze.

With its enveloping gauze, the kidney is now pushed back into its bed, the ends of the strips of gauze hanging out.

At this time, if preferred, secondary sutures of silkworm-gut may be inserted into the wound, or they may be deferred until the second operation.

Part of the wound may be closed in.

Iodoform gauze is now packed into the wound, and appropriate dressings applied.

The patient is put back to bed with the certainty that nothing has been done to add the slightest element of danger to the operation.

There is also no fear to be entertained that in the post-ether

vomiting the kidney may be torn from its anchorage, or that the sutures in the kidney may set up nephritis.

At this point we have a lesson taught us in plastic surgery by the behavior of gauze employed as a packing in an aseptic wound, or in one having aseptic areas.

Within twenty-four hours normal plastic lymph is thrown out into the meshes of the gauze, and the most intimate union is soon established between it and all points of contact with the wound.

So intimate is this union, that even at this early period it is with some difficulty that the gauze can be separated from the tissues.

The plastic process is so active, that in three or four days, unless sepsis has set in to soften and separate it, the gauze is found to be intimately identified with the tissue.

If we are certain of our asepsis, and the case does well, we can wait for a whole week, or longer, after the primary operation, before doing the second; but usually, if the patient has rallied from the first operation, in six or seven days the gauze packing and plastic strips may be removed under ether.

This can be done without anæsthesia; but the element of pain enters rather too strong a protest to be disregarded, and for many reasons it is wise to give an anæsthetic, of which very little will be required.

The gauze is carefully removed with the kidney *in situ*.

If secondary sutures have not been primarily inserted, they can now be introduced, and all tied except the middle one, which is perhaps best left open for four small gauze drains, run down on each side of the kidney.

These drains can be withdrawn in a day or two, and the remaining sutures tied.

After the wound has been healed and the sutures are removed, which can be done in eight days, the patient can be kept quiet for about a week to be certain of the healing of the wound, after which there is no danger, and the patient can be allowed to sit up.

In this operation there are no sutures in the kidney or its capsule to give away, and as the kidney is united by the firmest kind of union along its entire surface to the tissue of the bed in which it rests, there is no fear of displacement.

This union is identical with any other plastic union, except that the surfaces are here prepared for union by the exudative action of the gauze, and in ordinary plastic work denudation accomplishes the same purpose.

We might here mention an operation suggested and performed by Penrose.

He seeks, by rubber tubes carried around the poles of the kidney and up through the wound, to create cylinders of firm plastic exudate, which, after the withdrawal of the tubes in a few days, contract, and are expected to permanently support the kidney.

The writer of this paper is not favorably impressed with this operation. One which he saw done by another operator ended fatally.

The rubber would seem to be too much of a foreign body, and therefore apt to be irritating to the kidney, and not nearly as kindly disposed toward it as is gauze, and certainly not as efficacious in producing the effect sought for and so readily secured by the gauze method—namely, plastic “inflammatory” action and union.

During the past year a young lady dislocated her kidney, which I subsequently operated upon by the gauze method.

She has since subjected herself to the most severe physical tests, which ought by this time to loosen the kidney, if any thing would.

The organ is still firmly anchored, and is a most admirable evidence of the efficacy of the operation herein advocated.

In the original method of the elder Senn, he used the vertical lumbar incision of Simon.

The kidney is exposed, and the adipose capsule is excised over its whole posterior surface.

The rest of the capsule is pushed inward away from the posterior border of the organ.

The fibrous capsule is now scarified with a needle.

A strip of iodoform gauze about one inch in width is placed under the lower pole of the kidney, and the end left hanging out of the wound, one on each side.

By making traction with this strip, and a pair of volsella forceps catching the fibrous capsule, the lower pole of the kidney is brought into the lower angle of the incision.

The floor of the wound is then packed so as to force the para-renal fat away from the border of the kidney, which leaves the posterior scarified surface exposed.

This is covered with the strip used in packing.

The rest of the wound is now tamponed, over which the strip of gauze under the lower pole of the kidney is tied.

In five or six days the tampon and gauze are removed, and presumably the wound closed.

The younger Senn modifies the elder's operation by removing the gauze packing beneath the kidney in six days, but leaving the gauze sling remain eleven days, when it is removed.

By this modification the younger Senn seeks to secure on the floor of the wound a support made up of connective tissue, induced by the gauze packing, and a suspension by a band of cicatricial tissue generated by the strips.

Deaver still modifies Senn's operation by using two strips, one beneath the upper and the other beneath the lower pole of the kidney, after which packing is used, over which the strips are then tied.

The gauze is removed in a week or ten days.

I prefer the oblique incision as affording an easier route to the kidney, and as permitting readier manipulation.

The younger Senn makes a distinction between the new-formed tissue resulting from packing and that produced by the strips.

The first he terms connective tissue, and the other cicatricial tissue.

In my opinion the two forms of tissue are identical, and there is no necessity for the double removal of packing and gauze sling, as recommended by the younger Senn.

This unnecessarily prolongs the period of healing, and as the purpose is to fix the kidney in the wound, the method of the elder Senn, as modified by Deaver, seems preferable.

My own plan is to remove the gauze at any period from six to eight days after operation, and then close-in the wound, replacing a very small amount of gauze to serve as a drain,—thus securing, not connective tissue or cicatricial tissue, but an absolute union, except where the gauze drains may have left avenues for the filling-in of new-formed tissue.

If the wound is perfectly clean, this drain may be reduced

to a wick, which can be withdrawn in a day or two and the wound entirely closed; or, after the first removal of the gauze, the wound may be sutured throughout its length.

The advantages of the operation are as follows:

1. No suture in kidney or capsule; hence the organ is not injured, nor is the capsule stripped from the organ.

2. No subsequent fear of suture separation, nor of sepsis or irritation.

3. The operation is easily and quickly performed.

4. Union of the kidney with the adjoining tissues is of the strongest possible kind, and is uniform over its entire surface. This union is practically primary.

5. The kidney is permanently retained in the position in which it is placed.

The disadvantages may be summed up as follows:

1. A wound left open several days—an objection obviously of slight force in the present stage of aseptic surgery.

2. The necessity for a second anæsthesia and operation—like-wise of little force, because the anæsthesia need not be very profound, and the slight operative procedure is quickly over.

PREGNANCY AND CHILDBIRTH AMONG THE ANCIENT SCANDINAVIANS.

BY FRANK H. PRITCHARD, M.D., MONROEVILLE, OHIO.

SEVERAL years ago I received a pamphlet from a Norwegian physician, Dr. A. L. Faye, who had gathered a great deal of ancient literature on the old Scandinavian customs relating to pregnancy and childbirth amongst these our ancestors. Though we are not wholly Norse in origin, yet the Northmen so inter-married with the Saxons in the early days of English history, and their religion and customs were in so many ways similar to those of the Anglo-Saxons, I have thought it might be of interest to translate some of this, for to me it has been entertaining reading.

The old Norse songs of the Middle Ages are wont to give the duration of pregnancy as forty weeks, which was looked on as the time which the Virgin Mary went with child. Sv. Grundt-

vig ("Danmarks Gamle Folkeviser," Part II., p. 408), in the song, "Hustru og Mands Moder," when his wife asks him,

"How long should a woman go with child?"
(Huor laenge skal quinde med barnit gaa?)

answers,

"I fyrretiffue ugger och icke mer,
Ganger hun lenger, da bliffuer det hindis doed."
(Forty weeks, and no more.
If she go longer, it will be her death).

In the meantime the wife had been bewitched by his mother, and as the spell could not be loosened, she had also to die. In another variant of this song the husband asks his mother how long a woman should go with child. She answers, "Forty weeks and a year." "That is not true, for Mary went thus forty weeks with Christ," he answered.

"Then they drank at their wedding,
* * * * *
Forty weeks after, to the day,
She bore a son so gladly (?)."

An old Swedish book on midwifery puts the time in rhyme :

"Tio veckor swaang.
Och tjuge veckor traang
Och tio veckor jaemn till barnafaang."

In some songs and in other writings nine months is spoken of as the right length of pregnancy. In the *Rigsthula* of the *Edda* it goes on to say that *Rigr* first tarried three nights with the old married pair, "Aae and Edda," and nine months after the latter bore a son *jodh-ol* who became the "Stamfader" or progenitor of the bondsmen. Then he staid three nights with "Ave and Amma"—grandfather and grandmother—and the same time with "Fader" and "Moder," and each time the women gave birth to a child nine months after. From the first descended the peasants, and from the second the noblemen.

The law of some parts of Norway required the wife of a man who died while she was pregnant at once to notify the other heirs as to her condition. If a child were born from seven to nine months after his father's death, it could inherit.

The laws of the *Ostragoths* required that if a widow should be killed, and it be suspected that she was with child, then

the body should be disinterred and examined to see if it contain a child; if so, that child would cause the mother's heirs to inherit the father's property.

A child born dead or unbaptized was, as a rule, disqualified from inheriting in Scandinavia; an unbaptized child could not be buried in the churchyard. "Tha skal that ey i kirkiu garth grafua oc ey arff taka."

In case of doubt of pregnancy the woman was examined after the twentieth week—from the middle of the forty weeks—for then the child would "get life" and move.

"The queen walked upon the strand,
Then she found the child quick in her womb;
It was not over five months (twenty weeks)
Till the queen lay in
And bore a son so bright."

As other signs of being with child the Norse laid weight on the increase of size of the abdomen, the growth of other parts, and the appearance of milk in the breast.

"Den tid jeg ud af landet fór
Da var i en jomfru saa troest,
Nu tykkes mig i sinde min
I tyknes for eders bryst."

In a song from Thelemark, a mother asks her daughter:

"Kvi renne der mjokk otor brystinne din?"
(Why does the milk run out of thy breasts?)

The daughter answers:

"Aa dedh aer no inkje mjokk, um dedh synast saa
Men, dedh er den mjoeden, eg drakk igaar."
(That is no milk, though it seem so, but the mead I drank yesterday.)

The mother, who knows a thing or two, hints to her that mead is brown and milk is white; then the daughter confesses that

"Bergekongin nordh han hev lokkadh meg."
(The north mountain king has led me astray.)

When the Queen Sofie accused King Woldemar's sister of having borne a child in his absence, he looked her over and could see no increase in the size of her abdomen. Then the

Queen took his sister's breast in her hands and milked a stream on to the King's feet. "My noble Lord! Do you believe my word?" He had his sister whipped to death, and her lover, Buris, who had "cast runes"—kastet Runer—for her, was seized and put in a monastery. In a Norwegian variant it says:

"Ho rykte upp liten Kjersti's soerereim
Ho spraente mjokki paa kungjens fang."
(She [the queen] jerked open Kjersti's girdle;
She sprinkled milk upon the king.)

As long as a woman went with child she enjoyed certain privileges. If any one should happen to kill one he must pay a higher fine—Wehr geld. This custom prevailed amongst the Northmen, but it is only mentioned in the Swedish law-Landlov. In Germany a pregnant woman had a right to take any fruit, green vegetable or game which she might crave.

It was generally believed by the people that both pregnancy and childbirth might be prolonged by supernatural means. The Queen of Hunaland having long been barren, finally became pregnant by eating some apples which the goddess Frigga had sent her, but she could not bring forth at the right time. She then went pregnant for seven years; after the death of the king she became tired of life, and had her belly cut open. A big son, Voelsung, was taken out, who kissed his mother while she was dying.

Stories are told of other women who have given birth to children old enough to talk, etc.

One should treat a pregnant woman very carefully, that the child be not harmed nor childbirth be rendered hard. Many curious beliefs were held in Scandinavia which closely resembled each other. For example, one should never put a handle into an axe in the same room where a pregnant woman is. One should never hew into the threshold of a door, for if a woman with child first go over it, her child will have a hare-lip. In Denmark it was thought dangerous for a woman to walk over the spot where a hare had lain. In many places in Norway to-day it is the custom to cut the upper lip away on all the hares trapped, for fear that a pregnant woman see it and her child have a hare-lip. If a pregnant woman look at a snake or a wild beast, her child will be marked by that animal on that

part of the body at which she looked. She should not look at a cat, for the child will have cat's eyes.

This old belief that a child might be marked by its mother being frightened by seeing a thing is one which we often meet with to-day. I have seen children marked by burns, snakes, strawberries, and even by a flounder.

The Northmen were much averse against their wives witnessing the breaking of criminals on the wheel for fear that they would bear children with crooked limbs.

They also were superstitious with regard to certain things having a baneful influence on childbirth. If, for instance, a pregnant woman should move a thing, as a table, she should never walk backwards, or she would have a breach presentation. Neither should she walk under knotted cords which were stretched out; that would cause her to have a difficult labor. In certain parts of Norway it is believed that the navel cord will be as many times wound around the child's neck as the mother happens to pass under a rope.

In Sweden, if a pregnant woman has been weaving, and has tied up the warp, if she be seized with labor-pains, then she must untie all these strings, or her child will have the falling sickness (epilepsy).

In Norway, if an unmarried woman fasten the four corners of the caul of a colt to four stakes and creep naked, at midnight, under it, she shall become able to bear children without pain, but her sons shall be were-wolves and her daughters incubi; if the eyebrows join together over the root of the nose, that is a sure sign that such a person is a were-wolf.

If a bride on coming home from the church after the wedding at once jerk the bit out of the horse's mouth and hit him over the nose with it, at the same time loosening the bellyband of the harness, she shall have easy labors. Any one in Sweden who had separated a frog from a snake which was trying to swallow it would become gifted with powers of helping women in labor.

In Nordfjord district, in Norway, it is said that a pregnant woman should not drink out of a barrel, or her child will be wide-mouthed; nor eat any fruits which may be double on one stem, as strawberries or cherries, for it will cause her to have twins. A bride in the old days in Sweden would have as many

children as she thrust fingers under herself while seated in the "bride's chair." A pregnant women should never approach a corpse, or her child will have a bad breath. Up to a certain time in pregnancy a pregnant woman should never pass her water in a graveyard for fear that her children will always be wet.

Bears were supposed, in the early days in Scandinavia, to be eager to devour women pregnant with boy-children; they were thought to tear the mother to pieces and eat the fœtus as a great delicacy.

"So laenge skal de bjoennir vera
Og heran paa skogin gange
Til de teke banit or mors maga
Og foedher up till mannae."

Pontoppidan, "Forsoeg Paa Norges Naturlige Historie," ii., 24, asserts that bears are greedy after pregnant women. "They smell them afar, and try to get the child, which they esteem a great delicacy, especially if it be a male." Other Norwegian tales claim that it will not touch a girl-child. If one call a bear "grandfather" it will not harm any one. The Laplanders give the name "grandfather with the hairy coat" to bears. Women in Norway were not allowed to eat certain parts of the bear's flesh.

It is related in Rolf's Krake's Saga that his powerful warrior, Bodvar Bjarke's father, had been enticed, through witchcraft, into a bear's cave by his malicious stepmother. His wife, then with child, was forced to eat of his flesh, taking three bites; the third morsel she did not swallow. She finally gave birth to triplets, of which the first two looked half like animals, and the third was mute.

The Norsemen believed that if a woman be surprised by a bear, if she throw off her garments the bear would be so overcome by shame that he would at once turn and run away.

In olden times, in Norway, one of the greatest insults to a man was to accuse him of having been a woman and borne children. According to the elder Gulathing law, a man became outlawed if he said to another that he became a woman every ninth night and bore children.

"That heitir yki ef madhr maelir um annan that er eigi ma vera ne verdha, kvedr han vera konu niunda nott hverja, oekku

barn borit ok kaller gylvin (hermaphrodite). Tha er han utlagr." ("Gamle n. Love," 138.)

In the Njaals Saga it is related that in Iceland a reconciliation was about to be made between two parties, when one of the persons present, Njaals Soen Skarphedin, threw up to his enemy, Flose, that he was turned into a woman every ninth night, and had intercourse with demons in Svinafjeld, near his castle. That meeting broke up in a fight.

When Loke jeered the Scandinavian gods, Odin retorted that he had been under the earth for eight winters as a milchcow, and as a woman who had borne children.

. . . . "Kyr molcandi oc cona og hefir thu thar barn of borit."

In another variant of this tale, Loke is said to have given birth to the horse Sleipner.

(To be continued.)

THE USE OF PICRIC ACID IN EROSIONS OF THE CERVIX.

BY ARTHUR W. YALE, M.D., PHILADELPHIA, PA.

THE therapeutic value of picric acid in the treatment of burns has been satisfactorily demonstrated in our large hospitals, and it is now widely used by the profession at large. In most instances it has superseded other local applications by virtue of the fact that it is not only antiseptic, but it also exerts a mild, stimulating influence upon the skin, and encourages it to granulate. It is generally conceded that after the use of picric acid the resulting scars show less contraction than with any other local applications. The precise scope of picric acid as a therapeutic agent has yet to be clearly defined. Much has been claimed for it, but these claims have not been supported by sufficient clinical evidence.

Some months ago, while considering the unsatisfactory methods of treatment usually employed for erosions of the cervix, the idea occurred to me that picric acid might be of use in cases of this character. Accordingly I determined to consult our medical literature on the subject, but found little or nothing in all the various *materia medicas* to which I referred.

Many claims were made for it, but I failed to find any reference to its therapeutic value in cases of erosion of the cervix.

In spite of this fact, however, the excellent results which I had obtained from it in the treatment of burns encouraged me to test it for cervical erosion. Now, after having made a trial of it in my clinic for diseases of women at the Children's Homœopathic Hospital, I cite a few cases, selected from a number treated, as illustrative of the action of picric acid in different pathogenic conditions:

1. Mrs. B., 30 years of age; multipara; three children. Cervix torn laterally, forming an anterior and a posterior lip. The anterior lip was elongated, being about an inch long. Where the torn surfaces rubbed, erosions had formed, which were very sensitive to the touch. After two applications of picric acid, the erosions disappeared.

2. Mrs. M., 30 years of age; multipara; two children. Retroflexion, with erosion of the cervix. One application of picric acid healed this.

3. Mrs. C., 37 years of age; multipara; five children. "Tumor" removed over ten years ago, since which time she has given birth to two children. Cervix torn and ulcerated, with small pustules and an eroded area opposite the posterior lip of cervix on the vaginal vault. Upon first inspection the cervix presented the appearance of incipient carcinoma. Two applications of picric acid resulted in restoration of the parts to their normal appearance.

4. Mrs. M., 25 years of age; epileptic; multipara; four children. Erosion of cervix in this case disappeared after two applications of picric acid one week apart.

5. Mrs. S., aged 24; one miscarriage. Uterus was found to be in ante flexion. One application to an eroded area upon the cervix restored its normal appearance.

6. Mrs. N., 24 years of age; multipara; two children. Cervix in this case was very sensitive, and upon examination was found to be very sore and bleeding. The entire cervix was apparently almost completely denuded, and presented a raw appearance. This was caused by the patient endeavoring to produce an abortion upon herself by the use of a knitting-needle. A thorough application of picric acid checked the bleeding, the soreness disappeared, and the cervix returned to

its normal condition. It will be of interest to observe that gestation in this case proceeded without interruption.

The method of applying the picric acid is as follows:

With pledgets of cotton the vaginal vault and the parts of the cervix unaffected are carefully dried, the eroded area being left untouched. Where the surface to be treated presents a somewhat dry condition, it is found necessary to moisten it with plain water or an antiseptic solution, such as bichloride or formalin. With a pair of applicator forceps a pledget of cotton is grasped, the end of which is flattened, and upon it are dusted crystals of picric acid. This is carefully placed against the eroded surface, and held against it for a couple of minutes, till the picric acid is dissolved by the moisture.

In this way the application of the acid is made to the denuded areas only, the dried parts dissolving none of the acid. The picric acid sinks deeply into the tissues; and in several instances, directly after the treatment, I have placed a boro-glyceride tampon in the vagina to correct the displacement. This has interfered but little with the action of the picric acid.

Under this treatment erosions of the cervix have healed more quickly, with less discomfort to the patient (and in many instances without any return), than with tincture of iodine, ichthyol, carbolic acid, iodoform, or tannic acid, to all of which I have given a trial.

POISONING BY PICRIC ACID.—Drs. Achard and Clerc, in a case of burn of the cheek with a hot iron, where the wound had been rubbed with picric acid, observed toxic symptoms follow. That same evening the patient complained of itching of his whole body, and noticed that his face had swelled. On the third day his whole body, arms and legs were covered with a scarlatiniform eruption; the volar surfaces of his hands, as well as the soles of his feet, were full of numerous painful blisters; no fever. In about eight days the eruption had disappeared, and his hands and feet desquamated. Examination of the patient's blood revealed a considerable increase of eosinophile cells, even 15 per cent. of the leucocytes, which gradually decreased during the course of weeks. It is a question whether this eruption be wholly due to the picric acid, for a case of typical scarlatina eruption has been noticed after a slight burn of the right forearm. The exanthem which covered the whole body vanished, to be followed by pronounced desquamation. Only an oxide of zinc ointment had been applied to the wound.—*Centralblatt fuer Chirurgie*, No. 25, 1901.

EDITORIAL.

DANGERS PECULIAR TO THE INVALID OF EXALTED STATION.

Now that fearful suspense and vacillating hopefulness have given way to the calmness of settled sorrow at the sad results of the assassin's deed, we can give utterance to some of the thoughts suggested by the case.

It would be a most interesting subject for thought to endeavor to determine the mental constitution of those who style themselves anarchists, and to trace out the line of reasoning by which, starting out with the demand for absolute personal liberty of thought, word and deed for every one as their fundamental principle, they come to regard it as a duty to remove by death those who merely represent views differing from their own. Surely this is in itself enough to prove an obliquity of mental vision incompatible with a sound mind. But insanity which prompts to murder should, according to our view, be ended surely and speedily by death,—not as a punishment, but as a means of self-protection on the part of the community. Why burden society with the charge for years, perhaps, of a useless and dangerous individual? His reformation, if possible, is only possible through death.

The thoughtless demand for freedom, or rather license, of speech and of the press, leaves out of sight entirely the fact that those who talk and write are not generally the ones who act. On a little higher mental plane than their degenerate dupes, these instigators of foul deeds, while arousing the worst passions of their followers to overt acts, and sheltering themselves under the guaranteed freedom of speech, are none the less responsible for the acts which follow their teachings, but which they are too prudent and too cowardly to commit.

But the thought which has most forcibly suggested itself to us while reading the history of this lamentable case, and which has more interest for us as physicians, is the increased danger incurred by any one high in station, by reason of his exalted position, in the event of illness of any kind.

However glibly we may be inclined to repeat that all men are born free and equal, in our inner consciousness we feel that this is not so, and that, besides the inequalities of birth, reflected in the mental and moral natures, there are certain inequalities of fortune and position which render one life of more value than another. In most cases, to the individual his life is the most valuable; but in the eyes of the community, the state, and the world, the life of him is the most valuable in whom the most interests center, and upon whom the greatest responsibilities rest. With this higher valuation of a life comes an increase of responsibility to those who may be called upon to protect it or to seek to preserve it. From this, in some cases, almost overwhelming sense of responsibility arise the dangers which threaten one occupying an exalted position if he should be unfortunate enough to require medical or surgical treatment.

In the first place, the feeling of apprehension on the part of the attendant is enhanced in proportion to the valuation set upon the life of the sufferer, and with this comes, too, the desire to divide the responsibility, and one or more consultants are summoned. Now, although it is true that in a multitude of counsellors there is (a sum total of) wisdom, it does not necessarily follow that all of this is directly available for the benefit of the one most needing it. Although the numerous satires written on medical consultations of former years are no longer as true to nature now as then, can we conscientiously maintain that consultations are invariably resultant in good for the patient? Is the good accomplished proportioned to the number of consultants? We think not; and the common satirical remark that "So and so got well in spite of having had two doctors" reflects a similar popular distrust. With the increase in the number of consultants increases also the danger of irreconcilable differences of opinion, leading to delayed action or compromise measures. Aside from the depressing effect upon the patient of this increase of attendants, the actual result may, as we see, only increase the danger.

If it be kept in mind that these remarks are not to be taken as applying to the present case specifically, but as only suggested by it, we will not be misunderstood when we quote various correspondents of one of the daily newspapers, show-

ing that the dangers here referred to are not imaginary. We read, "The rumors of coldness between Dr. — and the other doctors should not detain us. It is easy to give a dark interpretation to a really harmless episode, and — is not a man to sulk like a schoolboy; moreover, the situation is too grave for professional jealousies." Unfortunately human nature, and even professional human nature, has the property of generally remaining a pretty constant factor in all our actions.

In another and almost diametrically opposite direction, the number of advisors may prove an element of danger. It is a danger which depends upon suggestion, that word which is so much in evidence at the present day, and the full import of which is but imperfectly comprehended. Who of us has not found himself at times influenced in his diagnosis or treatment by the report or discussion of some case which has had points of resemblance to our own? Or who has not, even in consultations, in spite of the most determined independence of thought, found himself liable at least to be biased in his opinion by the statement of the case given and the point of view taken? The greater the number of those thus gradually brought under the influence of suggestion, the more firmly does each become convinced of the correctness of the general view, and the less likely are other possibilities to meet with the consideration and study which their importance may demand. In the case before us, and with the intention only of proving the existence of this danger, we point to the generally expressed view that sepsis and peritonitis were the dangers to be feared. All the attendants were agreed upon this point; all looked for signs of these conditions; no one found them, and all were hopeful. But, according to the statement of one of the physicians, "The breastbone showed a big impact. Still, the area of infiltration of subcutaneous tissues was entirely too extensive to be accounted for from contusion or the force of the bullet. The subcutaneous tissues were in a partially gangrenous condition. . . . The skin wound on the point of entrance was livid and gangrenous, and this process extended to the entire line of invasion made by the surgeons through the abdominal wall." Here was a condition of the external wound which surely could have been seen at the repeated re-dressings, and

which, to a mind uninfluenced by cumulative suggestion, might have pointed to a similar condition within, such as was found at the autopsy. While nothing could have been done to change the final result, the prognosis would have been a different one, and the terrible shock of disappointed hopes spared us all.

Again, the tremendous responsibility to be incurred often prevents that immediate energetic action which determines the difference between fatality and recovery. In the case of an obscure individual chances are taken, and there is no delay. Fortunately this danger was in the present case avoided; but that it is a real danger can be seen from the following quotation: "This avoidance of delay, if I may be pardoned for saying it, was due to the fact that within a few minutes after the shooting there were at the President's side two surgeons with the 'audacity' to go ahead with the operation, which they knew was essential, without waiting for the consent of cabinet officials, for a general consultation of surgeons, or for anything else."

Further, on account of remote possibilities, any slight departure from the regularly reported routine assumes a more serious aspect, more or less detrimental to that calmness and self-confidence on the part of the attendants which react so favorably on the patient. We quote again a reference to the reopening of the wound: "If it had happened in an ordinary hospital patient, not a word would have been said about it. . . . If anything happens, we'll tell you when the time comes. You can depend upon that, no matter how rattled we may be."

Finally, the frequent issuing of bulletins, demanded by the anxious public, has a tendency to divert the minds of the attendants from the general course of the trouble by limiting their attention to the conditions found just at the moment of making their observations upon which each bulletin is based. Of course, taken by themselves, such observations are an index of the apparent condition at the time, but it is only by a rigid comparison of observations taken at longer intervals that a judgment as to the progress towards recovery or its opposite can be arrived at. Naturally, such comparisons are supposed to be made, and no doubt are made; but the tendency is to place too great reliance upon the isolated observations. The

frequent examinations are apt to allow slight and apparently insignificant changes to occur, whereby the mental picture of the progress of the disease is gradually altered, whereas these differences observed at longer intervals would become more marked and significant. Only in exceptional cases, according to our view, are the frequent examinations and visits necessary, which we hear of so often as proof of a physician's interest in a case.

Although, as is now evident, the fate of our lamented President could, under the circumstances, have been none other than it was, the fact remains that, when sick, the one of exalted rank or position is exposed, by reason of his eminence, to dangers at the hands of his friends which do not threaten one of humbler station.

A THERAPEUTIST GONE MAD.

A GERMAN physician has proposed what he is pleased to call a *new* cure for tapeworm. Had we not heard of it before—and proposed seriously, at that—we might have thought it new, or believed that the originator intended to perpetrate a tremendous joke on a serious profession. The learned author says, “Give the patient a small dose of the ordinary remedies, so as not to inconvenience him. As soon as the worm protrudes from the rectum, inject it with 0.01 of morphia or a solution of cocaine, after which the worm dies and is easily passed.”

Just think of the above coming from a serious German savant! Surely it is just as easy to strike the worm with a shoe or something, and stun him, as he looks out of the anus, as it would be to inject him with the expensive cocaine, and run the risk of his acquiring the cocaine habit—for, doubtless, worms have habits as well as habitats.

This new cure reminds us of an old device for killing potato bugs. The method was advertised as infallible. The purchaser received a small package which he was requested not to open until ready to use. Then he found two small blocks, with directions to catch the bug, put it on one block, and mash him with the other.

GLEANINGS.

AN INTERESTING CASE OF CEREBRAL HEREDO-SYPHILIS.—Dr. Gaucher recently reported before the French Société de Dermatologie et Syphilographie the case of a young woman of 19 years, who, delivered a month previously, was admitted to the hospital with coma, right-sided hemiplegia and aphasia; on auscultation, a bruit de galop was to be heard, and albumin was found in her urine. (Such a set of symptoms would lead one to think of apoplexy from interstitial nephritis, until better informed.) On examining the patient attentively, he found such characteristic dental changes that he felt justified in diagnosing hereditary syphilis, though no other stigmata were to be detected; acquired syphilis could be excluded. Inunctions of mercurial ointment were given, and in fifteen days an evident improvement was to be seen; in a month and a half she left the hospital entirely cured. Since then she has returned on account of gummata of the legs, whose syphilitic nature confirm the diagnosis of the previous brain-troubles. His researches in the literature of this subject have demonstrated that cerebral symptoms may complicate hereditary syphilis; they have always been laid to a gummatous meningitis, but in this case he is inclined to ascribe the condition to an arteritis of the arteria fossæ Sylvii. The alterations in the patient's teeth which attracted his attention were the dwarfed and eroded state of the four lower incisors and the atrophic canines, while in the upper jaw the incisors, though normal in size, were eroded. But the most important and pathognomonic state was that of the four molars, which were worn off and eroded on their upper surface, an important sign of hereditary syphilis. Her child died the day after its birth; her husband abandoned her. She had become pregnant immediately after marriage. He thought himself able to exclude acquired syphilis, for one would hardly expect such cerebral symptoms after nine months and gummata after twenty-one months.

Prof. Fournier stated that his experience has led him to expect brain-symptoms at about the age of this patient—between eighteen and twenty-two years. He has never seen a case develop later. He insists on the capital importance of these dental changes, which alone may be present, and be such a valuable hint as to save the patient's life. He would place as signs first in importance Hutchinson's notched teeth, then decuspidation of the molars, and, finally, "la dent en tornevis" (the screw-driver tooth), whatever that may be!—*La Semaine Médicale*, No. 20, 1901.—(Dr. Donner—"Ueber Späetformen Angeborener Syphilis"—in *Form Einer Casuistik*, 1896, p. 82, gives as an example of one of the consequences of inherited syphilis, later forms, the following clinical picture: "With some anxiety, the father, conscious of the disease which he has acquired in a thoughtless moment in his youth, looks forward to the birth of his child, for he has heard that syphilis may be transmitted to one's children. He rejoices that an apparently healthy

child has been born which thrived in spite of some trivial troubles, which were laid to anæmia, weak nerves or scrofula. . . . The son, the pride and joy of his father, up to his twelfth year, has been the picture of health. In school he has, by industry and gifted mind, excelled in all his classes. All at once complaints reach the parents of a lack of industry in school, of faulty attention, and of all sorts of stupid tricks which one would hardly expect from so good a boy. Even his parents have noticed that his character has changed, and that his ways are different, but they think that that will soon disappear of itself. All at once, while the boy is enjoying himself at his games, an epileptic convulsion throws every one into consternation; one follows the other; the boy's mind fails rapidly, so that any one notices it. He is taken from one physician to another, but all is in vain. And if the parents are not so fortunate as to find one who recognizes the specific nature of the disease, their child is irretrievably lost. He will either die in a short time or spend the remainder of his days in an idiot asylum.")

Frank H. Pritchard, M.D.

INFLAMMATORY EYE DISEASES IN NEW-BORN CHILDREN.—Dr. Groenouw has examined bacteriologically the secretion from the inflamed eyes of one hundred new-born infants. In forty cases no bacterial cause could be determined; in the others, forty-one times there were gonococci, five times pneumococci, twice streptococci, four times the staphylococcus pyog. aureus, once the micrococcus luteus, and seven times a bacillus which resembled the bacterium coli. The greatest interest was aroused by the conjunctivitis from gonococci; in twenty-four cases this was intense, in four moderately so, and in eleven only a slight blenorrhœa.

Conjunctivitis from gonococci in new born infants may manifest itself merely as a mild catarrh, while, on the contrary, a typical blenorrhœa is not always associated with gonococci.

Seven weeks was the average duration of the gonorrhœal form. Corneal affections complicated the forty-one cases ten times and they were never noted in the non-gonorrhœal cases. As a rule they began in the second to the third weeks. Serious cases of blenorrhœa were accompanied by great perforating ulcers, while the milder form only gave superficial ones. He thinks that treatment is unable to prevent corneal lesions. As to treatment, he attempted to compare the nitrate of silver with the organic salt, protargol, the former in a 2 per cent., the latter in a 5 per cent. solution. His conclusions are rather unsettled, but he advises protargol 5 per cent., as it may be used several times a day without fear of overdoing treatment.—*Hospitaltidende* No. 13, 1901.

Frank H. Pritchard, M.D.

CARDIAC THROMBI IN A CASE OF DIPHTHERIA.—Prof. V. Leyden, at a meeting of the Berlin Society for Internal Medicine, related the case of a young girl of fifteen years who died after having been affected for three or four days with a grave form of diphtheria. She had received four thousand and five hundred units of antitoxin in two injections; this was followed by slight improvement, when all of a sudden she died. He had noted how frequent this mode of death was in epidemics of the most serious form of diphtheria. As soon as a physician observes that a child with diphtheria commences to suffer from decided dyspnœa he should be on his guard, for often in a few hours paralysis of the heart sets in, with death. The necropsies in

such cases generally show the heart to be somewhat enlarged, with more or less pronounced fatty degeneration of the muscular fibrillæ, and not rarely one may find blood-clots originating in the fasciculi at the apex of the heart. Leyden also noted the clots in his case, and called particular attention to them, as they form during life and are an expression of great weakness of the cardiac muscle; and, in a disease as violent in its course as diphtheria, they constitute a curious post-mortem finding. The other changes are those of acute infectious myocarditis, fatty degeneration of the fibrillæ, small areas of fibrous degeneration, and accumulation of yellow pigment.—*Rivista Critica di Clinica Medica*, No. 4, 1901.—(Cocaine is a good drug in this condition.)

Frank H. Pritchard, M.D.

A FOREIGN BODY IN THE NOSE GIVING RISE TO SYMPTOMS RESEMBLING TUBERCULAR MENINGITIS.—Dr. A. Ruault was called to a child of four years who had been taken ill with fever, violent headache, vomiting, frequent crying out, opisthotonos and rigidity of the neck. By careful questioning it developed that the child had thrust an acorn into one nostril. This was removed, after which the meningitic symptoms disappeared.—*Centralblatt für Chirurgie*, No. 16, 1901.—(Inflammation of the middle ear should not be forgotten where children seemingly are suffering from meningitis, and particularly if the opisthotonos is pronounced. Dr. Barlow, in the article on posterior basilar meningitis in Albutt's "System of Medicine," calls attention to the beneficent influence of an early paracentesis of the tympanic membrane in such cases. Possibly the brain lesion is the continuation of an earlier infection of the middle-ear.)

Frank H. Pritchard, M.D.

A CASE OF PRIMARY EPITHELIOMA OF THE UVULA.—Oppenheimer (New York) reports a very interesting case of primary epithelioma of the uvula occurring in a man 81 years old. Patient gave a good family history, had always enjoyed excellent health until a few years previously, when he developed bronchitis, from which he has since suffered. He presented a slight paralysis of the right side, resulting from a stroke of apoplexy which occurred a few years prior to the examination. He had complained for a year or more of irritation of the throat, but the results of examination always proved negative, until within a few weeks a thickening at the tip of the uvula was noticed. This increased until a growth the size of a walnut was visible, which involved the entire uvula from its tip to its junction with the soft palate. The growth was bluish-red in color, firm to touch, but not ulcerated; the adjoining tissues presenting nothing abnormal. The only pain the patient complained of was a slight radiating pain to the ears, the cervical glands being slightly enlarged. Microscopic examination showed the stroma to be the seat of considerable inflammation, the epithelial cells were arranged as in a typical epithelioma, nuclear changes being present, as shown by numerous mitotic figures indicating rapid cell proliferation. Operation was not deemed advisable on account of the age of the patient, the glandular involvement and his general impairment of health. Oppenheimer recommends early removal if diagnosed as primary epithelioma and the patient is in good health, as there is little tendency to recurrence at this site. He says, "Of interest in this connection is the fact that the location of the growth seems to exercise a restraining influence upon the natural tendency of this form of malignant disease to spread."—*Medical Record*.

Bernard E. Bigler, M.D.

DIETETIC TREATMENT OF EPILEPSY.—R. Balynt discusses the present status of the therapy of epilepsy, and comes to the conclusion that we have not advanced materially towards checking it. The observations of the writer and several others point to the fact that bromine acts better when the chlorine in the body has to a great extent been removed. In the treatment of his cases he applied a diet which was free from chlorine and gave bromides with the food. The diet consisted of milk, butter, three eggs, and bread (nine and one-half to twelve and one-half ounces). No salt was given, and the estimated amount of salt in the food was under thirty grains. To the bread he added bromide of sodium instead of the chloride. The effect on the attacks was extraordinary, some being suspended while others were lightened. In 80 per cent. of the fresh cases the "fits" ceased. His conclusions are: (a) a diet poor in chlorine should be tried in every case of epilepsy; (b) the treatment is most successful when carried out in a sanitarium; (c) beside the diet, small doses of bromine salts should be given; (d) the easiest way of giving the drug is to let it take the place of chloride of sodium in bread; (e) these principles may be carried out in other nervous cases where the bromides are used.—*Berl. Klin. Woch.*

William F. Baker, A.M., M.D.

THE COMBATING OF TUBERCULOSIS IN THE LIGHT OF THE EXPERIENCE THAT HAS BEEN GAINED IN THE SUCCESSFUL COMBATING OF OTHER INFECTIOUS DISEASES.—(Prof. Robert Koch.)—In an address delivered before the British Congress of Tuberculosis, Dr. Koch puts forward the following: After some general remarks as to the amount of misery produced annually he makes this statement: "The fact that tuberculosis is a preventable disease ought to have become clear as soon as the tubercle bacillus was discovered and the properties of this parasite and its method of transmission became known. The combating of the disease should not be left alone to a small body of physicians, but should have the co-operation of the state authorities. We have learned from the other infectious diseases how they have been transmitted, and how to act to prevent their spread, and how each disease requires its own care for its prevention. We are entitled to success in the treatment of tuberculosis only if we keep this lesson in view." This point is illustrated by several examples.

The methods of infection are then reviewed, and the question of hereditary transmission fully discussed. The transmission of tuberculosis from infected animals next receives attention. Genuine tuberculosis has been observed in all domestic animals, particularly poultry and cattle. In experimenting on cattle which stood the tuberculin test, nineteen were infected with tubercle bacilli in various ways; some received tuberculous sputum direct, others were injected, and some had it introduced into the circulation direct. Six animals were fed with it in their food. None of these showed any symptoms of the disease, nor could any manifestation of the disease be found in any of the internal organs afterward. At the points of injection small foci of pus were found. The results were quite different, however, when the cattle were injected with tubercle bacilli that came from the lungs of an animal who was suffering from bovine tuberculosis.

After a period of one week the severest disorders of the internal organs broke out. High fever set in, and the animal became weak and died. After death it was found that extensive tuberculous deposits were at the site of in-

jection, and in the lungs and spleen. The difference between bovine tuberculosis and human was as marked in experiments on other animals.

While it can be stated that human tuberculosis cannot be transmitted to animals, the question came up as to the susceptibility of man to bovine tuberculosis. It is a well known fact that milk and butter contain large amounts of the bacilli of bovine tuberculosis, and we would expect to find frequent cases of alimentary infection in children, but this is not so. If it is so that man can be infected, then the cases are very scarce. *The extent of infection by milk and butter and meat is hardly greater than that of hereditary transmission, and it is not deemed advisable to take any measures against it.* By far greater is the danger from the sputum of already infected human subjects. This should be taken care of and disinfected.—*Lancet*, July 27, 1901.

William F. Baker, A.M., M.D.

THE EFFECT OF SO-CALLED CATARRHAL DISEASES OF THE NOSE AND THROAT ON THE GENERAL HEALTH.—Carolus M. Cobb says that diseases of the nose and throat affect the general health in several ways, principally by extension of diseases of bacterial origin, and those diseases resulting from obstructed nasal respiration.

The diseases of bacterial origin affect the general health: (a) by extension on the surface of the mucous membrane; (b) the migration of bacteria to the surrounding tissue or to other parts of the body; (c) by swallowing of the discharge; (d) by absorption of the toxins. The lymph channels and the blood are the means of conveying the bacteria. The infection thus produced does not differ materially from ordinary septic infection. By this is meant an infection from any other source. It is well known that many of these patients suffer from indigestion, and it is fair to assume that the continued swallowing of the discharges from these diseased conditions could produce that state, or at least aggravate it. A condition of chronic sepsis may be caused by a purulent collection in the nasal cavities or accessory sinuses.—*Journ. of the American Med. Assoc.*

William F. Baker, A.M., M.D.

THE PATHOLOGY OF HYSTERIA.—T. D. Savill says that hysterical attacks differ from all others in that they can be produced in a large number of instances at will by pressing on the inguinal region. Pressure exerted on this region produces either a syncopal attack which resembles the aura of a hysterical seizure or a sensation rapidly rising from the groin or abdomen to the chest, and forming in the throat the "globus hystericus." At times bystanders can hear the attempts of the patient to swallow the "ball." In other subjects pressure produces a feeling of "faintness and sinking in the abdomen." This symptom should not be called, as it is by some, "ovarian tenderness," for it has not the slightest resemblance to it. It should be described as the "hysterogenic phenomenon," or "inguinal phenomenon." It may be observed in the male. The points of pressure should be called "hysterogenic zones." These zones are never on the limbs, although they may be scattered over the trunk. In some patients pressure on one zone will produce an attack, while pressure on another will stop it. By far the commonest zone is that supplied by the ilio-hypogastric. This nerve is centripetal, starting from the skin over the buttocks and the inguinal region, and passing into the abdominal cavity, where it joins the lumbar, and comes in close relationship

with the solar plexus. There are many reasons for believing that these attacks are due to a sudden dilatation of the abdominal vessels. If this reasoning is correct, we can see how pressure could produce the symptoms concomitant with the hysterical aura. The ilio-hypogastric nerve is apparently the centripetal depressor nerve of the abdominal sympathetic, and irritation of it by pressure in this region produces dilatation of the splanchnic area, and consequently cerebral anæmia. There may be other depressor nerves in patients who present other hysterogenic zones.—*Lancet*.

William F. Baker, A.M., M.D.

TREATMENT OF INFANTILE DIARRHOEAS.—According to W. H. Roby, the treatment is divided into three general methods: (a) cleansing of the bowel of bacteria and their toxic products; (b) stopping the further development of bacteria by rendering the conditions unfavorable to their growth; (c) supporting the patient against constitutional symptoms. Perhaps one of the best facts brought out is the necessity of guarding against infection of others by carefully washing the hands after handling the stools. Care should be taken that the household food be not infected. Good results have been obtained from washing the bowel with tepid salt solution by means of a soft rubber catheter; from one to two quarts are used. If vomiting is profuse the stomach should be washed also. Food should be stopped for twenty-four hours, and when it is resumed sterile diluted milk should be fed cautiously.—*Phila. Med. Journal*.

William F. Baker, A.M., M.D.

THE MANUAL CONVERSION OF FACE POSITIONS INTO OCCIPITAL POSITIONS BY THORN'S METHOD.—(Opitz).—The writer draws his conclusions from an experience of seventy-one cases. The method was successful in over seventy per cent. of them. The technique is as follows:

The internal and external hand acting on the head and breech of the child convert the lordosis of the face presentation into the kyphosis of the occipital position. The hand corresponding to the back of the child is introduced into the vagina up to the head, so as to obtain a purchase on the cephalic prominences or about the fontanelles. The face is then lifted out of the pelvic brim and attempt made to flex the head on its transverse axis, so as to direct the forehead toward the breast. If necessary, two fingers can be hooked over the occiput to draw it down with the aid of the external hand. At the same time the breast of the child is pushed outward and a little upward, and the breech in the opposite direction till the normal position of kyphosis is produced. It is advisable for the patient to lie on her side with the hips elevated for this position, especially if the head is deep in the pelvis. Considerable stress must be laid on the importance of raising up the face from below, and the introduction of the occiput into the pelvis from without.

Opitz concludes with the following remarks:

Any considerable delay in labor in face presentations makes worse the prognosis for the child, and justifies interference.

The mobility of the head, independent of the position of the chin, is the most favorable condition for the conversion of the facial into an occipital position. It is advisable to wait for sufficient dilatation of the cervix before performing manual reposition. If Thorn's method fails, introduce the hand corresponding to the child's face along the posterior wall of the uterus, and pass four fingers up over the occiput and pull it down with the aid of the external

hand. The thumb will lie over the brow, and rotates it at the same time that the face is lifted up from the brim. The position of the body is to be improved at the same time, when possible.

No more force must be used than is absolutely necessary, and the physician must not leave his patient afterward.

If reposition has been accomplished successfully, the fœtus must be kept in position by placing the patient on the side corresponding to her back, and whenever possible the head should be pressed down into the pelvis. Labor can be left to terminate spontaneously after the head has entered the pelvis and become fixed, but if there are any signs of approaching asphyxia, or if labor is not completed in three or four hours, the forceps should be applied.

If the attempt at reposition fails, or if the face presentation soon recurs, one can wait and see if labor is not soon ended with better pains. If the pelvis is contracted, immediate version and extraction is necessary. It is also indicated if labor is protracted, or if indications for delivery develop. Manual reposition is contra-indicated in cases of external pelvic contraction, 9 cm. conj. or under; cases in which the spontaneous delivery of a vertex presentation cannot be expected, also prolapse of cord, placenta previa, and distension of the lower uterine segment with the head already fixed in the pelvis.

Version should be performed at once in the first two cases.

If there is marked distension of the lower uterine segment, extremely careful attempts may be made to rectify it by pressing the face up with the internal hand and the occiput down with the external hand. If it fails, or if the attempt is not advisable, perforation must be performed.

If the head is fixed in the pelvis, and the chin is posterior or rotates more and more posteriorly, spontaneous rotation forwards will ultimately take place in most cases, and the accoucheur should wait for some urgent indications for delivery. If such occurs, carry two fingers up over the chin, and endeavor to rotate it forwards; failing in this, firm external pressure on the occiput may force the face down in the pelvis; but do not attempt Thorn's method, on account of the danger of rupturing the uterus. Perforation and extraction with the cranioclast then becomes necessary.—*Zeitschrift für Geburtshilfe u. Gynäkologie*, Bd. xlv., H. i, 1901.

George R. Southwick, M.D.

ECLAMPSIA.—The following opinions were advanced at the May meeting of the German Gynæcological Society in Giessen:

The prognosis must be guarded in all cases. About 20 per cent. of mothers and 28-44 per cent. of the infants in the lying-in hospitals perish. In general, the earlier the convulsion the worse the prognosis. Puerperal eclampsia is not by any means a simple affair, and may assume the most severe type and end fatally. The prognosis is affected by the duration of labor after convulsions begin, by the intensity, number and duration of the convulsions, and the duration of the intervals between them. Coma is important regarding its depth, rapidity with which it occurs, and its duration in the intervals. Death of the child diminishes local irritation, and is favorable rather than otherwise. Number of labors influences the prognosis and also the condition of the urine. Increased diuresis and a diminution of albumin and casts are usually favorable. High temperatures, which have gradually advanced with successive convulsions, are not necessarily unfavorable; but the same cannot be said of high temperatures previous to the convulsions and a continued rise

of temperature after cessation of the attacks. The following rules of treatment should be observed :

1. The patient should be delivered as soon as possible, but carefully and without undue traumatism, and without too much attention to the interests of the child. If the cervical canal is undilated, use Hegar's dilators and introduce an elastic dilator, *i.e.*, a metreurynter. On account of the danger of hæmorrhage Dührssen's incisions should be reserved for a nearly dilated cervical canal, though the external os may be closed. Caesarian section may be performed during the last moments of the mother's life in the interest of the child.

2. All obstetrical manipulations must be performed in narcosis, owing to the increased reflex irritability.

3. The utmost care must be taken to secure asepsis, as the eclamptic intoxication predisposes to sepsis.

4. There should be strict individualization in the use of remedies having a poisonous effect on the heart or kidneys, and to limit them to the actual necessities of the case on account of the possible after-effects and failure to eliminate the toxins. Such remedies are chloroform, chloral hydrate, morphine and veratrum viride. Morphine should not be used with a frequent small pulse. The combined treatment of chloroform inhalation with enemata of chloral hydrate are recommended.

5. Every possible means should be taken to eliminate the toxins by exciting the secretion of the kidneys, skin and intestinal tract. The hot pack must be used cautiously on account of the danger of cerebral hæmorrhage.

6. Venesection and saline transfusion have a useful place in diminishing blood-pressure and diluting the toxins.

7. The inhalation of oxygen increases the oxidization of the blood, and by it the destruction of the toxins of eclampsia.

8. Use stimulants in case of threatened cardiac collapse, as ether, camphor or caffeine.—*Centralblatt für Gynäkologie*, No. 25, 1901.

George R. Southwick, M.D.

ENLARGED PROSTATE.—Wallace (England), speaking of the treatment of this disorder, says :

"I may say that it is now generally recognized that to initiate a patient even temporarily into what is termed 'catheter life' is a proceeding fraught with much danger, and not uncommonly followed by loss of life. Secondly, I think it is also recognized that the chief risk is associated with the occurrence of sepsis, organisms being introduced at the time of catheterization, and that such an accident may result notwithstanding every precaution which may be taken. Indeed, personally there is no class of surgical interference which causes me more anxiety than the passage of a catheter for the first time in a case of over-distended bladder due to enlargement of the prostate." The writer advises the use of a soft rubber catheter, as it can be readily sterilized by boiling, and if that fails, use a silver catheter. A gum catheter is not as good as either of the others, as it cannot be purified so certainly. If the bladder be over-distended and the contractile power probably lost, do not evacuate all the urine at once. If the bladder be not so markedly over-distended and still contractile, empty it completely, but introduce a few ounces of warm boric lotion or boro-glycerine in water. Of the operative procedures the author suggests: (1) Castration, and modified procedures based on the

same theoretical grounds, vasectomy and angio-neurectomy; (2) drainage, suprapubic or perineal; and (3) suprapubic prostatectomy. No mention is made of the Bottini operation. His plan is to employ castration, or perhaps vasectomy where the enlargement mainly proceeds from blood engorgement, and suprapubic drainage or prostatectomy in cases of fibrotic prostate, or where the enlargement is due to prostatic tissue resembling an adenoma.—*The Lancet*, July 13, 1901.

Gustave A. Van Lennep, M.D.

RELATION OF EYE-STRAIN AND PNEUMOGASTRIC REFLEXES TO DIGESTIVE DISORDERS.—A. L. Benedict says that if we allow the use of the term "eye-strain," not in the usual sense of an effort to correct a visual error, but just as we would speak of cardiac strain, or strain of any other normal part by over-exertion, he is prepared to admit that it is a very frequent cause of acute gastric symptoms, such as nausea and vomiting. It is not safe to say that sick headache is always due to eye-strain, but it does often result from a depression of pneumogastric function by ocular reflexes. The frequency of sick headache in summer is quite as much due to straining the eyes in brilliant sunshine for a long period as to the danger of fermentation in food on account of the heat.

Scorchers' sick headache is a good example of the result of eye-strain caused by the effort to fix the eyes on the road while subject to constant vibration of the bicycle. The streaming past the field of vision of objects in the road, the brilliancy of illumination on a sunny day, etc., constitute an overexertion of the extrinsic muscles, the ciliary and the iris, as well as a prolonged and marked stimulation of the rods and cones.

Car-sickness is, in some persons, a closely analogous condition, and due to the same detailed cause.—*Annals Ophthalmology*.

William Spencer, M.D.

THYROID TREATMENT AND OPTIC NEURITIS.—The usual symptoms of thyroidism, emaciation, weakness, shortness of breath, nervousness, etc., are well known, but there are others occasionally observed that are less generally appreciated. If we are to regard exophthalmic goiter as the result of hyperthyroidization, we can see possibilities in the way of unpleasant symptoms that have not all been actually observed from the therapeutic use of the extract. However that may be, it is probable that observations on the increasing therapeutic uses of the drug will from time to time bring out many important additions to our knowledge of its effects.

One such has been editorially noticed in the *Medical Press and Circular*.

The reference to the record is not given, but it states that Dr. Coppez, of Brussels, reports the cases of five patients, four of them women, in whom prolonged thyroid treatment for obesity produced well-marked optic neuritis, occurring several months after the beginning of the treatment, but then progressing very rapidly, vision being reduced to one-tenth in the course of a few weeks. No other symptoms of thyroid intoxication appeared in these cases, but in some of them suspension of the administration sufficed to relieve the condition, and its connection with the treatment seems, therefore, obvious. As the writer remarked, henceforth the inquiry as to the use of thyroid treatment will be in order in cases of optic neuritis of obscure etiology.—*Journal American Medical Association*.

William Spencer, M.D.

ECLIPSE BLINDNESS, WITH THROMBOSIS OF THE RETINAL ARTERY—HÆMORRHAGE INTO THE VITREOUS.—Dr. R. D. Batten has reported the case of a woman aged 28, who watched the eclipse of May 28, 1900, without other protection than "screwing up the eyes" and looking between her fingers held close together.

Objects immediately appeared black, and next morning she could see only "portions of things."

On June 6th, when she was first seen, she had lost the lower half of the field of vision in the left eye, $\vee = \frac{6}{18}$. Above the disc was a white patch, possibly an absorbing hæmorrhage, and the hazy edematous retina obscured the view of the disc and retinal vessels.

The edema increased until June 20th, and then rapidly cleared, leaving a patch of choroido-retinitis above the disc. One of the upper retinal arteries was occluded, and the others were reduced in size. The vitreous opacities cleared and the macula was unaffected.

Vision improved in the injured eye to $\frac{6}{12}$. In the right eye it was $\frac{6}{6}$.

Mr. Lawford said that he had observed three cases of eclipse blindness, but without ophthalmoscopic signs. In all, however, the scotomata had persisted, with deterioration of vision. Mr. Jessop had published three cases. In all, vision improved, but there was a slight permanent scotomata. Mr. Bokenham gave details of two cases, in one of which there was retinal hæmorrhages. Vision improved from $\frac{5}{60}$ to $\frac{6}{12}$, but there was a marked central scotoma. Dr. G. A. Berry thinks the scotoma is usually permanent in the worst cases.

The public is not aware that blue glasses are worse than useless in looking at the sun and bright objects. It is blue and violet rays which do damage. In Russia, red or yellow glasses are employed.—*Jour. Am. Med. Association.*

William Spencer, M.D.

A NEW PROGNOSTIC SIGN IN TYPHOID.—The *Monthly Homœopathic Review* (Aug. 1, 1901) quotes from the *Medical Age* concerning the recent researches of Waldvogel, which go to show that, in the majority of cases of typhoid, the congelation point of the serum is much increased, and that if this elevation does not occur, the case of typhoid will inevitably die. Waldvogel's conclusions are based upon researches conducted in twenty-four cases of typhoid fever. The normal congelation point of serum is 0.56. The highest points observed were in two convalescents, 1.68 and 1.28; and the lowest were in three cases that died, 0.65, 0.63, 0.54. The high point in convalescents proves that it is not due to the patient's temperature; special studies prove that these patients are not uremic; and Waldvogel is convinced that this elevation of the congelation point can only be due to the presence in the blood of a typhoid antitoxin. If this be true, prognosis founded upon this relative congelation acquires a solid basis.

F. Mortimer Lawrence, M.D.

INTESTINAL OBSTRUCTION FROM A GALLSTONE.—Dr. Ehrmann, at a recent meeting of the Medical Society of Nuremberg, on account of the relative rarity of intestinal obstruction from gallstones, reports such a case. The stone naturally gains entrance to the intestine through a fistulous communication between the bowel and the gall-bladder. The wife of an inn-keeper, of fifty-three years of age, two years previously had first suffered from gallstone colic. This recurred three times during the first year. During September of

last year she suffered from a febrile affection, with swelling of the liver and gall-bladder, which were sensitive to pressure. This condition lasted about six weeks. The swelling in the region of the gall-bladder disappeared, *i.e.*, the stone ulcerated through into the large intestine. After a hearty meal about a month ago, she was again seized with what seemed to be an attack of gallstone colic. The vomiting gradually became feculent; neither flatus nor feces were passed. Yet the umbilical region was but slightly sensitive to pressure, nor was there any meteorism which is supposed to be characteristic of intestinal obstruction from a gallstone; pulse very weak; collapsed, sub-normal temperature and great weakness. In spite of irrigation of the stomach and high rectal injections, neither the fecal vomiting lessened, nor was there flatus or stool. On the fifth day an operation was done, and a gallstone weighing 28.2 gms. was removed from the ileum, about one meter below the pylorus. She reacted well, and recovered entirely. She was discharged in three weeks. On account of her collapsed condition, Schleich's infiltration anesthesia was employed until the peritoneum was opened, when chloroform was given for a short time. The stomach was washed out each day, and quite a quantity of normal salt solution was left in the abdominal cavity. The bowel was but little changed, and the stone was removed by an incision which was closed in three stages.—*Muenchener Medicinische Wochenschrift*, No. 30, 1901. (I recently had such a case where goodly doses of atropine, with olive oil internally, brought my patient out safely. The German journals have been reporting quite a number of cases of intestinal obstruction which were relieved by atropine pushed to the point of toleration. Olive oil seems a useful adjunct.)

Frank H. Pritchard, M.D.

SEVERE POISONING FOLLOWING THE USE OF A LIQUID SHOE-BLACKING.—Dr. Lop, of Marseilles, recently observed a young man who had a pair of tan shoes, which he colored black by means of a liquid shoe-dressing. He wore these for eight hours, and was seized with cramps in the calves of his legs, cyanosis of his face and extremities, anuria, subnormal temperature, etc. Investigation revealed the disturbances to be due to the aniline contained in the liquid shoe-blackening.—*La Semaine Medicale*, No. 32, 1901. (Prof. Landouzy has reported similar cases in this same journal in 1900.)

Frank H. Pritchard, M.D.

PREVENTIVE TREATMENT OF DIPHTHERIA WITH ANTITOXIN.—In a discussion at a recent meeting of the Paris Pediatric Society, the question of the value of the anti-diphtheritic serum as a preventive came up. Dr. Ausset declared that its value could no longer be doubted. He has employed it over five hundred times, and no longer hesitates to employ it in private practice. It is never too late to act in diphtheritic cases, though certain forms of very toxic diphtheria are, even if injected the very first day, still dangerous; but prophylactic injection will prevent such cases from developing. Dr. Barbier does not think immunization so very useful, for many cases have been observed after prophylactic injection. Dr. Netter admitted that it was not an absolutely certain preventive, yet it serves to limit infection. It may be assumed that 10 per cent. of children coming in contact with diphtheritic patients will contract the disease. His statistics of 32,484 cases which were

prophylactically injected, showed only 192 to have become infected, *i.e.*, about 6 per 1000. Prophylactic injection does not prevent carrying out the other measures, yet it decreases the difficulties of an epidemic by diminishing the number of patients, rendering their isolation and disinfection less laborious. Prof. Comby regards immunization absolutely harmless and very useful. He employs it in private practice, without waiting for a bacteriological examination. Dr. Sevestre thinks this measure devoid of danger, yet certain byphenomena, as skin eruptions, may be bothersome. If he is able to visit both the ill and well children twice a day, he does not inject the unaffected ones, but, in case of the least doubt, he hastens to inject.

It was the consensus of the society that the injections are without danger, and confer immunity for several weeks in the great majority of the cases. Therefore, they recommend it whenever a case of diphtheria breaks out amongst several children, or when strict surveillance is impossible.—*Munchener Medicinische Wochenschrift*, No. 30, 1901. (Chantemesse, at a recent meeting of the Paris Société des Hôpitaux, communicated extensive statistics to show that anti-diphtheritic injections of serum should be made as soon as possible, without even waiting for a bacteriological or a clinical diagnosis, but apparently on mere suspicion. From his experience of the past year he can assert that the injections are harmless. He has also noted that serum which has been kept for a considerable time and contains flocculi of fibrin is active, and is less frequently the cause of erythemas than fresher serum.)

Frank H. Pritchard, M.D.

ORBITAL HETEROPLASTY BY GRAFTING A RABBIT'S EYE INTO THE CAPSULE OF TENON.—In a brief communication, Lagrange calls attention to the fact that Rohmer's failure to successfully graft an animal's eye into the capsule of Tenon in the human being should not militate against the operation, as the technique was faulty.

He says that the capsule should be free from blood before the eye is introduced, and that instead of closing by the purse-string suture, the ends of the muscles should be carefully approximated and the wound closed by interrupted sutures. He describes three cases in which he successfully grafted the eye of rabbits into Tenon's capsule.

At first there was a rapid shrinkage of the resulting stump until the grafted organ had reached about one-half of its original size. After this no change occurred. The resulting stumps were well formed and freely movable. In one instance the operation was a failure, due likely, he says, to the fact that the grafted eye was too large, being taken from an old rabbit in whom vitality was in all probability reduced. He believes that great care is necessary during the preparation of the case and the procedure. The capsule must be thoroughly clean, and all hæmorrhages should be arrested before the graft is introduced. In addition, before cutting the muscles, the sutures should be inserted into them for the purpose of drawing them together to close the wound. Further, the conjunctiva must be carefully closed with interrupted sutures, and the eye selected should be from a young rabbit or from one of medium or small size. The conjunctival sutures may be removed on the tenth day.—*La Clinique Ophthalmologique*.

William Spencer, M.D.

THE PATHOLOGICAL ANATOMY OF ARCUS SENILIS.—Takayasu's communication is probably the largest contribution to the pathology of arcus senilis.

His studies were made on twenty eyes of persons from 50 to 90 years of age. After sections were made, he finds that the principal changes in the cornea consist in the presence, in the latter, of very fine granules.

He describes very minutely the various histological characteristics of that part of the cornea occupied by the arcus, and he sums up his conclusions as follows: The little granules color readily in the so-called "Sudaulösung," while either a chalky or hyaline material is uninfluenced by this stain. The granules are stained black with osmium. The granules do not react to hæmatoxylin, eosin, or to Von Gieson's stain. Alcohol causes them to run together and disappear entirely. They are not to be found in preparations hardened with alcohol.

He concludes that the granules are fat granules, and that the arcus senilis is nothing more than a fatty degeneration of the corneal substance.—*Archiv. für Augenheilk.*

William Spencer, M.D.

THE ETIOLOGY OF OPHTHALMIA NEONATORUM.—Schausz has found that the disease which we have always regarded as an infection due to the presence of the gonococcus is, in a large majority of cases, unassociated with this organism.

Possibly the first experiments to cast doubt upon the truth of this opinion were made under Neisser's direction.

In ninety-two cases of blenorrhœa neonatorum the gonococcus was absent in twenty-nine cases. While Widmark, in one hundred and three cases, found the gonococcus absent in thirty-nine cases, Klopstein, in fifty-one cases of severe blenorrhœa, found the gonococcus thirty times; and, finally, Groenouw examined one hundred cases, and found the gonococcus in only forty-one cases. A number of other organisms have been found in this class of cases, such, for instance, as the pneumococcus, streptococcus, Koch-Weeks bacillus, etc. Any of the last-named organisms may produce a blenorrhœa with all the typical symptoms.—*Zeitsch. für Augenheilk.*

William Spencer, M.D.

DISAPPEARANCE OF EPIPHORA, AND THE CHANGES IN THE LACHRYMAL GLAND AFTER EXTIRPATION OF THE TEAR SAC.—His experimental work upon rabbits leads Tscherno-Schwartz to the following conclusions:

1. A certain time after the removal of the tear sac the epiphora will get less, and finally disappear.

2. The epiphora can now and then reappear under the influence of irritation. Its intensity, however, stands in inverse ratio to the lapse of time after the operation.

3. The cause for the cessation of the epiphora after the removal of the tear sac lies probably in the compensatory atrophy of the corresponding lachrymal gland.

4. The cessation of the lachrymation and the existence of changes in the lachrymal gland after removal of the tear sac would justify one in concluding that there is some sort of connection between the two organs.—*Zeitschr. für Augenheilk.*

William Spencer, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

REMARKS UPON CERTAIN SKIN AFFECTIONS, by Dr. Bourzutschky (*Zeitschrift des Berliner Vereines Hom. Aerzte*).—It is refreshing occasionally to come across an article in which a man of wide experience and discriminating intellect tells of his successes and failures as well, and lets us feel that we need not question either his diagnostic ability or his veracity.

Eczema.—In this affection *Graphites* has invariably disappointed him, even in the presence of special indications, and when given in single doses. *Sepia* he considers a very important remedy. The favorite location is the back of the hand. It is a dry eczema. General *sepia* symptoms need not be present. *Natrum mur.* is his favorite in *moist* eczema, without marked itching, the favorite seat being the face, bands of joints, and nape of neck. In moist eczema of infants *Viola tricolor* is preferable. Strong smelling urine belongs especially to *Viola*.

Mercurius.—Skin affections occurring in patches; itching violently, especially at night; characterized by inflammatory reaction and moderate exudation. Also useful in eczema of leg due to varicose veins. In the latter cases, when an acrid discharge is present ("Salzfluss"), *Arsenicum* is specific.

Sulphur.—He is at a loss to define anything characteristic of sulphur in eczema; even itching is not a *conditio sine qua non* according to his experience. He cites a case of dry eczema of four years' standing in which scales formed plentifully about the hairy border of the scalp, behind the ears and on the temples, and in which itching was absent, that was promptly cured by sulphur. However, itching is usually present when sulphur is indicated, and the case is preferably chronic in nature and of the dry variety. [No remedy compare-with sulphur in usefulness in *eczema erythematosum* either as it occurs in children on the palms of the hands and soles of the feet, or as it is frequently seen in pronouncedly lithæmic subjects, attacking the legs or arms. The skin is bright red and dry, almost glazed, about the color of a boiled lobster. There is burning and itching, aggravated by washing in plain water.]

Ledum.—Facial eczema, occurring in dry scaly patches, discoloring the skin but slightly. Inflammatory reaction and itching are slight.

Petroleum.—The indications for *Petroleum* are confined to *eczema rhagadiforme*. It affects the hands, which crack deeply, even to bleeding. In such cases the hands should never be put into water unless glycerine is applied before they are dried off. At night they should be anointed with vaselin. If the lower potencies fail to act, the medium potencies will give results. In one case that did not respond to *Petroleum* he followed with *Sulphur*, and a cure followed. Concerning the homœopathicity of *Petroleum* to rhagadic eczema, Dr. Bourzutschky relates the case of a servant of his wife who was advised

to drink coal oil for violent stomachache, and being benefited thereby, continued to take it. In consequence of this the typical lesions developed upon her hands.

Local Treatment.—He considers local treatment, excepting in the impetiginous variety, of no consequence. The main purpose is to remove local irritation. When crusts form, vaselin is the least irritating application. Dusting-powders have disappointed him in moist eczema, and he rarely uses them excepting on the prepuce or vulva, and in severe impetigo. In the impetiginous variety mild antiseptic treatment becomes necessary, which should always be preceded by removing crusts after softening them with oil. Boric acid in solution is the least harmful antiseptic. The internal remedy in these pustular forms is *Hepar sulph.*, which rarely fails to cure.

Hyperkeratosis.—"If a man who, through the wearing of tight boots, developed a thickening of the epidermis came to a physician and asked him to be relieved of this evil through internal medication, one would with right designate this as a ridiculous request. This is, however, an affection of the skin in which the epidermis becomes greatly thickened without local irritation." Dr. B. continues in this strain to relate the case of a woman who, since several months, had been troubled with a gradually increasing thickening of the soles of the feet, for which she had received local treatment without result. *Antimon. crud.* 3x was prescribed, and a prompt cure followed without local treatment.

Furunculosis.—In furunculosis of infants *sulphur* is the most important remedy. In general it is the best remedy excepting in special cases, notably the following: Local furunculosis, at the nape of the neck, *Silicea*. Furunculosis accompanied by glycosura (not true diabetes), *Arsenicum*. He says, in closing, that the remedies were used in the lower potencies, excepting Graphites, which he had also tried in the thirtieth.

C. Sigmund Raue, M.D.

SOME REMARKS CONCERNING SILICEA.—Dr. Boesser, of Chemnitz, has an interesting article on *Silicea* in the *Zeitschrift des Berliner Vereins Hom. Aertzte* (July, 1901), from which we cull the following remarks: Headache ascending from the nape of the neck is found in no remedy as characteristically as in *Silicea*. It is a nervous headache, brought on by mental exertion, The pain is felt over the eyes; generally worse over the right eye. Aggravation results from noises, motion or jarring. Amelioration from binding the head up warmly. This it has in common with *Magnesia mur.* and *Strontiana carb.* Sharp drawing pains rise from spine into head. At the height of the paroxysm there may be nausea and vomiting. Many other subjective disturbances are also found. After the attack there is transitory blindness.

The remedies that are to be differentiated are *Menyanthes trifoliata*; *Paris quadrifolia*; *Gelsemium*; *Strontiana carb.* A certain similarity exists also with the headaches of *Spigelia*, *Sanguinaria* and *Belladonna*. *Spigelia* is a un-headache, and the left eye is most prominently affected. *Sanguinaria* has a headache originating in the occiput, but it is not of a spinal nature. *Belladonna* does not affect the posterior region of the head characteristically. In character it is a congestive headache and is relieved by sitting up.

NEURALGIA OF THE TONGUE.—A case of this rebellious affection cured with *Silicea thirtieth* potency, by Dr. Baumann, is cited. The characteristic

symptom present was a sensation of a thread or hair hanging from the base of the tongue down into the pharynx, inducing a troublesome and annoying irritation. She had also been a sufferer with typical *Silicea* headaches. The writer then mentions a case of

Insomnia, in which other remedies had failed, but on prescribing *Silicea* thirtieth potency, because of a tendency to spinal headache, the patient made a prompt recovery.

C. Sigmund Raue, M.D.

NATRUM PHOSPHORICUM IN CHILDREN'S DISEASES.—Dr. Heinrich Kesselring (*Homœopatische Monatsblätter*) recommends *Natrium phosphoricum*, sixth decimal trituration, in acute diarrhœas of infants characterized by greenish-yellow, chopped, lumpy stools of sour odor and often accompanied by sour vomiting. Colic is frequently present. He considers it an excellent remedy so long as the stools are not decidedly watery. According to Schuessler's theory (or vagary) *Natrium phosphoricum* is indicated in all disease states resulting from an excess of lactic acid in the system. Physiological chemistry is the coming science that will accomplish just such wonders for medicine as bacteriology has in the past, but when the medals will be awarded we do not think Schuessler, with his perverted homœopathy, will be able to receive a gold one.

C. Sigmund Raue, M.D.

SPIGELIA FOR SYMPTOMS DUE TO THE PRESENCE OF WORMS.—This remedy was introduced some time about the year 1748 as a medicine for destroying intestinal worms; and the old school is content even yet to know such a valuable remedy as a vermicide. Hahnemann, by provings, extended its field of usefulness, and precisionized its indications. Dr. Wm. Boericke has written a very helpful article showing its wide sphere of usefulness in therapeutics when selected according to law. (*Medical Century*, Sept.) *Spigelia* is a remedy for the symptoms due to the presence of worms, especially in strumous, feeble and precocious children. You will find in such cases that it will dissipate quickly such symptoms as fever, dry hot skin, constipation, capricious appetite, and nervous irritability or timidity. Such a child may refer much of its distress to the region of the navel (the similarity to *cina* will be noticed). It will prove beneficial in disordered states which *simulate* helminthiasis. In short, then, *Spigelia* cures because it has the power of producing the symptoms commonly met with in cases such as we have described. (From large doses of *Spigelia* we notice: Dilated pupils, flushed face, quickened pulse, heat and dryness of the skin, spasm of the facial muscles, convulsions, itching of the nares, nausea rising into the throat, burning red cheeks and lips, and marked abdominal pains.)

Dr. Stille, an acute old-school observer, mentions the fact that there is a state of intestinal derangement presenting all the symptoms of lumbricoid ascarides, which is most frequently observed among strumous, feeble children. Then he mentions a list of symptoms quite similar to those found in the pathogenesis of *Spigelia*, and winds up by announcing that "these symptoms are often dissipated by *spigelia* without causing the discharge of any worms." Thus does the dominant school unconsciously (?) testify to the truth of similia. Dr. Boericke calls attention to the fact that the provings of all anthelmintics show them capable of *causing* all the so-called "worm symptoms." This they do by acting as irritants to the intestinal tract, and arousing reflex irritation as

well as a direct irritant action on the brain and cord. They are, therefore, all homœopathic to worm symptoms; whether caused by parasites or other irritants in the intestinal canal. Both methods of administering the remedy—the large dose of the old school and the minute dose of the new—are rational procedures. The only advantage of the large dose being the *immediate* removal of the worms and consequent disappearance of the reflex symptoms. But, at best, this is but a *palliative* effect, for the condition of the system producing the favorable ground for the existence of the parasites remains unchanged. On the other hand, the minute dose of a properly selected homœopathic remedy acts *permanently* and *curatively* by changing the constitutional defects, giving rise to the favoring conditions of worm life. To accomplish this desirable end, the physician must treat his *patient* upon the totality of symptoms, rather than for the name of any particular disease.

O. S. Haines, M.D.

THE TREATMENT OF ANGINA PECTORIS.—Dr. H. V. Halbert believes that we may assume that a neuritis of the cardiac nerve plexus is the primary fault in an acute attack of angina pectoris. The ramification of these branches about the aorta and coronary arteries would account for the association of these parts with the paroxysm. Then, too, inasmuch as the plexus contains both sympathetic and vagus branches, it may be easily seen how a combination of an unusual amount of motor and inhibitory force would result in a spasm simulating angina. By accepting this theory of the cause of the disease, we may readily account for a variety of extreme manifestations when there are attendant organic conditions. We must look for the cause of the angina, not in the gross structural changes, but rather in the nervous workings of the heart. It very naturally follows that the author, having accepted this theory as the correct one, will advise us that “during the acute attack we must first of all relieve the pathology of the cardiac ganglion.” He would not overlook the requirements of antecedent and subsequent investigation and treatment of organic conditions or other heart perversions, but *during an attack he would, first of all, relieve pain*. For this purpose he counsels the *hypodermic* use of *Morphia*, and fearlessly uses *half-grain* doses. Indeed, “in severe cases” he has found it necessary to repeat *quarter-grain* doses hourly, three or four times, and says that the results have been most favorable. (*The Clinique*.) Is it really true that one is not justified in “looking for the indicated remedy while the patient is undergoing the sufferings of an attack of angina pectoris”? Will not our homœopathically indicated remedies act with the *requisite promptness* under such circumstances? This is a very important question. Dr. Halbert does not think so, evidently; and, moreover, he does not regard Amyl nitrite, Chloroform or Nitroglycerine with as much favor as the simple injection of *Morphia*.

O. S. Haines, M.D.

PEMPHIGUS.—In epidemic pemphigus, when the broken bullæ ooze an ichorous fluid which produces rawness wherever it touches. *The child picks at the eruption in a nervous manner until it bleeds*. Here *Arum tri.* was very successful. A few of the cases were complicated by follicular tonsillitis, salivation and swollen sub-maxillary glands. *Arum*, *Lachesis* and *Rhus tox.* are about the only remedies needed for this disorder.—C. M. Boger, M.D., in *Medical Advance*.

A VALUABLE MODALITY IN *NUX MOSCHATA* HEADACHES.—Dr. J. C. White relates a rather unusual case in the *July Advance*. A man, aged 30 years, was present when some servants were playing with a pistol cane. The arm was "not loaded," but, as is usual under such circumstances, went off when quite close to the spectator's head. A full charge of fine bird-shot entered the brain through the right parietal eminence. The aperture being enlarged, the brain substance was found to be broken down to the depth of an inch in depth and one and a quarter inches in diameter. The shot were removed, together with the debris of bone, hair and broken tissues.

There was subsequently complete paralysis of the right upper extremity, the lower being partly at command. Notwithstanding this injury, he gradually regained the use of both limbs, although his arm remained rather weak. During the second week of his illness, he was troubled with intense pain in the head. His moaning and other demonstrations of pain indicating its severity. Belladonna and Arnica did nothing for him. Morphia and Atropin also failed to relieve. Dr. White carefully studied the case symptomatically and found: The intense pain was only *relieved* when the nurse applied both hands to the head and "*pressed with all her weight*." Upon this singular modality *Nux moschata* 2. and 3. potency was administered. Its effect was very marked and quickly cured the patient. Dr. White does not find this modality in his repertories, and thinks it is deserving of notice.

O. S. Haines, M.D.

RHUS TOX. IN OCULAR DISEASES.—There is a class of cases in which I wish especially to emphasize the value of the *Rhus tox.*, namely, in *old injured eyes*. Cases in which the eye has been injured months or years previously, either by a blow, puncture, cut, or even perforating ulcer. The sight may be partially or entirely destroyed, and at times the eye tends to become inflamed, painful and sensitive to pressure or motion. The conjunctival vessels are engorged and there is circumscribed corneal injection, lachrymation, with or without photophobia. In such a case *Rhus* seldom fails to relieve. In more recent trauma, it is also serviceable, either accidental or operative cases, when there is a tendency toward inflammation, suppuration and destruction of the organ.—J. B. Hinson, M.D., in *New Eng. Med. Gaz.*

O. S. Haines, M.D.

AN AGGRAVATED CASE OF CONSCIENTIOUSNESS.—The patient is a physician residing in Chicago, and the case is such a rare one nowadays, that it deserves a moment's contemplation. This physician was called to treat a baby, aged thirteen months. She had been bottle-fed, was very slow in teething, so that but two lower incisors had appeared. Her illness began with a cold, which after ten days of treatment by ancient methods became complicated by severe gastric irritation and high fever, nausea and constipation. Then this physician was called. He found the child emaciated, pinched and wan. It could retain no food, its bowels would not move, it had a harsh, painful cough, thirst was excessive, and there was to be noticed a constant chewing motion of the mouth. Temperature was 102.5°. The hands were cold and it had "a far-away gaze of the eyes." This doctor rightly concluded that the child was threatened with cerebral effusion, and gave her *Bryonia alba* in the thousandth potency. It worked like a charm. The

child improved in every way. Next day, suddenly, after a nap, the child opened its eyes widely, gazed far away, clutched its thumbs and fingers, twitched about the mouth and had a spasm. This was followed by vomiting of clear fluid, and this again by complete relaxation and exhaustion. Then this doctor administered a dose of the thousandth potency of *Helleborus*. Again there came a magical response to the remedy. The child lost its fever, had several tarry stools and improved in all other respects. After this dose, no more medicine was given until it was observed that the child was too cool, was restless after midnight, and suffered from empty belchings. Then a dose of *Arsenicum*, in similar potency, removed all remaining symptoms, and the child began to eat and got entirely well, save some tendency to constipation, which another dose of *Bryonia* cured. The parents and friends showered unstinted praise upon the doctor and upon Homœopathy, just as they should have done, and everything was lovely. But, at this point, the physician became sick, and his ailment is, as may be shown, an *aggravated case of conscientiousness*. We are surprised that the true nature of the affection was not recognized in Chicago. It is very common in the East and used to be endemic here. The symptoms of this particular case are these, in the patients own words: "This case," says he, "was a splendid cure and was, from the family's standpoint, snatched from the grave; but from the viewpoint of science and a correct Homœopathy it is a different matter,"—"Bryonia was the similimum to the initial symptoms, Helleborus to the spasms and brain symptoms, Arsenicum to the continued nausea and general debility and to the periodical aggravations." "The three cured, but were the three needed?" "I feel that I was careless in my selections, that I even endangered my own success, that in short I simply *wobbled* to a happy termination in a very critical case." "Will not some sure-shot prescriber tell me wherein I made a faulty selection, in either remedy or potency?" "How should the case have been better handled?" "The best is none too good for me." Newton had this same disease, for it was said of him, "That nothing short of the most rigorous accuracy could satisfy *his* conscientious regard for truth." It did not kill him, however, and the prognosis is just as good in the present case. As a palliative measure, it may be remarked that according to § 248 of the *Organon*, the doctor treated the case exactly right in every essential particular. Doubtless he did not choose the *proper potency*, however. It was either too high or it was too low, but *which* we cannot, at this time, determine. Perhaps some one will enlighten him upon this knotty point.

O. S. Haines, M.D.

HÆMORRHAGE IN CASES OF GASTRIC ULCER.—To control the hæmorrhages in cases of gastric ulcer, Dr. A. E. Thomas says, we should first apply an ice-bag over the epigastrium. Then give a solution of the desiccated adrenal gland, stirred into two ounces of water. Soon after giving the adrenal gland, we may give five to ten drops of oil of Erigeron. If the hæmorrhage is very profuse, give with this treatment tincture of Erigeron or tinc. China or *Millefolium*—five drops at each dose, hypodermically. No food should be given by the mouth inside of thirty-six hours after a marked hæmorrhage. —*Medical Era*, August.

O. S. Haines, M.D.

THE HAHNEMANNIAN MONTHLY.

NOVEMBER, 1901.

A PLEA FOR SURGICAL INTERVENTION IN GALLSTONE DISEASE.

BY WILLIAM B. VAN LENNEP, A.M., M.D., PHILADELPHIA, PA.

(Read before the Penna. State Homœopathic Medical Society, at Pittsburg, Sept. 26, 1901.)

YOUR chairman has requested clinical papers of especial interest to the general practitioner, and I therefore propose to present to you two of the phases of gallstone disease. While some physicians are even yet dilatory in summoning surgical aid in appendicitis, bowel obstructions, head injuries, etc., the fact that these conditions are surgical and require early intervention is generally recognized. My desire is to impress upon my colleagues the fact that cholelithiasis, still treated medically in most instances, as were the above-mentioned conditions in the past, calls for more frequent and prompt surgical measures.

CASE I.—Male, 61 years; patient of Dr. T. L. Chase, to whom I am indebted for the previous history, as well as for the report of much of the after-treatment. He had always enjoyed good health, aside from habitual indigestion and constipation, and had been under observation for a little over two weeks with symptoms that led to the diagnosis of typhoid fever, such as, gradually rising temperature; headache, with pains in the back and limbs; progressive weakness, aggravated by the slightest exertion; loss of appetite; coated tongue; diarrhœa; enlargement of the spleen; abdominal distention and tenderness, and “typhoid” spots, together with a certain amount of

mental dulness, associated occasionally with mild delirium. The maximum temperature, 103° , was reached on July 21st last, the associated pulse being 132. On the 22d the patient was taken with a prolonged chill, followed by a temperature of nearly 107° , and a profuse colliquative sweat, with a thready, irregular, almost imperceptible pulse. These paroxysms of chill, fever and sweat recurred at irregular intervals, with increasing frequency and varying intensity during the next twenty-four hours, or until the writer saw him. They were typically pyæmic; that is to say, they showed no regularity in their recurrence, three or four at least having occurred during the morning of the day of operation. With this complication there appeared pain and tenderness in the region of the gall-bladder, and on examination a smooth, fluctuating, readily movable tumor was found below the right rib-border.

The patient was etherized just as another chill had set in, and by means of a vertical incision a very much enlarged gall-bladder was delivered from the abdomen. On opening the same, some eight ounces of a clear, limpid fluid were evacuated, and at the close of the flow *barely an ounce of pus*. This, of course, explained the pyæmic focus, which is often so small as to raise a doubt as to whether the cause of the trouble has been reached. After emptying the hydrops and pus, 112 gall-stones, varying in size from a horse-chestnut to a pea, were removed from the gall-bladder and cystic duct, a large calculus occluding the latter. The sub-hepatic space was walled-off with a protective pack of iodoform gauze, and a large catheter was tied into the gall-bladder to carry off the bile. Infusion was necessary at the close of the operation, when his pulse went to pieces during the sweat, the temperature, in spite of the shock, going over 105° .

There was no recurrence of the chill, fever and sweat seizures; peristalsis was re-established at once, and continued in fact as a diarrhœa, such as preceded the operation; bile at once appeared through the tube, and continued to discharge in decreasing quantity until healing was complete. The temperature run was an interesting one. Following the fall after operation and infusion there was a daily rise to 101° or over, characteristically subsiding, until at the end of three weeks it became normal. This was not affected by the gradual removal

of the gauze, nor by the washing out of the gall-bladder and ducts, and there was no wound infection to account for it. With the fever was associated a low, muttering delirium, such as had preceded the pyæmic complication; and this, with the diarrhœa, the temperature, and the other detailed symptoms, seems to justify the conclusion that the patient ran a mild, somewhat atypical typhoid, such a course as is not infrequently met with in those who have passed middle life. The mental condition caused considerable anxiety, the first inference being that it was dependent upon a uræmia, for examination of the urine before operation showed a low specific gravity, albumin and some hyaline casts; but the two latter disappeared, and the quantity of urine, at first small, as after all serious operations, quickly returned to normal. The only other possibility was that peculiar mental condition met with in the old, and which I am frank to confess I cannot explain, namely, increasing stupor and even delirium without recognizable lesion, which gradually ends in a death the cause of which we are wont to ascribe to asthenia.

It is a well-known fact that in cholecystic empyemas the typhoid bacillus is frequently present, and that such a condition is not an uncommon *sequela* of enteric fever; but the occurrence of this complication *during* the course of a typhoid, provided the diagnosis is correct, is a unique one in my experience, and at the same time it is one of the possibilities for which the practitioner must be on his guard.

From the standpoint of the operator in an obscure abdominal case, the fact of finding what appeared to be only a cholecystic hydrops in such a desperate condition was certainly a disappointment; but the final, small amount of "offending" pus was interesting to those who are familiar with pyæmia. I well remember one of the most classical cases of this disease I have ever met with. A parturient, colored woman, with a small, hot, tender, red nodule in the upper, outer quadrant of the right breast, who was suffering from irregular seizures of chill, fever and sweat, the temperature reaching 106° and over, recurring irregularly and with increasing frequency, the focus being an abscess whose capacity was hardly as large as a walnut. Incision and evacuation were followed by a recovery impressive as well as instructive to my college class.

CASE II.—Male, 44 years; seen with Dr. S. C. Webster, of Westerly, R. I. The patient presented a very characteristic history of severe gallstone disease, extending over several years. He had passed from time to time a number of calculi, some so large as to almost preclude the possibility of their having traversed the biliary ducts. This naturally raised the question of the presence of a fistulous communication between the gall-bladder or even between the common duct and the small intestine, the former being a not uncommon condition. A fistula with the large intestine could be excluded, for free bile had never been noticed in the stools. As will be seen later, the operation left the possibility of a common duct and small intestine communication in doubt. The patient had received all manner of approved medical treatment, and had been under the care of eminent physicians in New York, Boston and Providence. He furthermore gave the history of at least one severe and protracted attack of peritonitis, presumably localized and fibrinous in character, as the symptoms had subsided and no abscess had developed. None of the previous medical attendants had advised operation.

The writer was consulted on account of a persistent, classical picture of impacted calculus in the common duct, namely, deep and universal jaundice, dark urine, clay-colored stools, recurring paroxysms of pain, with constant pain radiating toward the umbilicus. The Mayo-Robson point, *i.e.*, midway between the ninth costal cartilage and the umbilicus, was exquisitely tender, and careful palpation revealed no enlargement of the gall-bladder. The value of the latter observation has been questioned by some, but, in my experience, calculous obstruction of the common duct has been characterized by jaundice and no palpable enlargement of the gall-bladder; while outside obstruction, malignant or cicatricial, or even stricture, has presented an appreciable enlargement of the gall-bladder along with the jaundice. The explanation of this phenomenon in a previous cholecystitis, with consequent cicatricial “non-distensibility,” is presumably familiar to every one. Aside from these symptoms, which, on previous occasions, had persisted for considerable periods of time, the urgent condition was the recurring chill, fever and sweat, which had become so severe as to threaten the patient’s life from asthenia. This, too, is not in-

frequently a misleading complexus, which I have more than once seen treated as malaria, and which will bear careful differentiation from the pyæmia of the former case.

The operation showed in a most instructive manner the necessity for a much earlier intervention. On opening the abdomen by means of a vertical incision, supplemented by one parallel with the rib-border to get more room, a most inextricable mass of dense, ancient adhesions was met with, which matted all the neighboring abdominal organs to an almost unrecognizable degree. On palpation, it was possible to feel what seemed to be a large gallstone, lodged presumably at the terminal end of the common duct; but to get at it was out of the question, on account of the adhesions. With great difficulty a thickened, closely-contracted, miniature gall-bladder was literally dug out from the under surface of the liver. During these manipulations there was no undue bleeding, as might have been feared in such an intense cholæmia. Cholecystenterostomy was naturally decided upon, but, unfortunately, neither the duodenum, the jejunum, nor even the ileum were accessible, so that the anastomosis was made by means of the Murphy button with the transverse colon, which could be readily drawn up against the deeply retracted gall-bladder. The wound was packed with iodoform gauze.

The after-course was an interesting one. The patient reacted well from the ether; and as he had been in the habit of taking morphia, we ran the risk of continuing the same. By the end of twenty-four hours peristalsis was established, and free bile was found in the stools. The urine, however, which, aside from the bile it contained, was apparently normal, decreased in quantity, until at the end of the third day he was passing but five or six ounces. On the fourth day his pulse went all to pieces, and the patient was apparently dying in collapse. The usual heart stimulants and a pint of saline infusion having no effect, between two and three quarts were given through the median basilic vein by Dr. Hassler; this induced prompt reaction, with a rise of temperature, improved pulse, free sweating, and increased urine up to sixty-nine ounces; the quantity came down during the next few days to normal. Following this reaction he developed a mental irritability with a moderate amount of delirium, which also gradually passed off. On the

day following the infusion, by the advice of Dr. Bartlett, suprarenal extract was given three times daily in five-grain doses, because the pulse, while fuller, seemed to lack tone. The apparent result was very gratifying. On the eighth day, much to our surprise, he passed a large biliary calculus, after which we found not only free bile in the stools, presumably coming through the anastomosis, but also a change in the color of the feces to normal. On the nineteenth day the Murphy button was passed, this being preceded by considerable griping pain. The remainder of the convalescence was uneventful, and the patient went home at the end of six weeks with a strong, firm cicatrix, and completely healed, with the exception of a small superficial sinus. The restoration to health appears to be complete.

I will only burden you with the records of these two cases, to a certain extent unique, it is true, and to a certain extent also extreme. Yet they show the ill-effects of procrastination in the latter, and the importance of intelligent vigilance in recognizing a rare but dangerous complication in the former. There are, of course, subsiding gradations from either case, and a summary of operative indications, with a brief mention of the pathological possibilities, may not be out of place.

Every one is familiar with the fact that many subjects go to the post-mortem table with extensive cholelithiasis without having presented known symptoms that would indicate the presence of gallstones. Such calculi are usually found in the gall-bladder, where they may multiply to almost any extent; but occasionally a quiescent stone may be met with in the ducts, as, for example, Richter's case, in which a common-duct stone weighed three and a half ounces; these calculi, however, if they produce no symptoms, must not interfere seriously with the flow of bile. Probably from 5 to 10 per cent. would represent the frequency of gallstones in all autopsies; furthermore, females suffer from the disease in the proportion of five to one as compared with males, thus just about reversing the ratio of appendicitis in the two sexes.

In view, then, of the above frequency and the common latency of gallstones, what conditions may they induce that will call for operative interference?

1. Stagnation and catarrh appear to be strong predisposing

factors in their causation, and this suggests not only the preventive treatment—medicinal, hygienic and dietetic—but the surgical procedure necessary to avoid recurrence. Drainage, often prolonged, of the bladder and ducts is a most desirable post-operative measure, and it is often well to associate this with a washing out of the latter. Duct catarrh, with its thick or inspissated mucus, not infrequently closely simulates gallstone colic, so that a failure to find stones does not necessarily mean a mistake in diagnosis, and the operation is curative. Stagnation, with catarrh and distention, may also be induced by malposition, the latter being dependent upon vicious pressure, such as tight corsets, etc. This, too, can be corrected by incision and drainage.

2. Given the continuous formation of calculi—the gallstone habit, if you please—and their repeated expulsion, with the consequent recurring attacks of hepatic colic, operation is indicated both as a preventive and curative measure, *i.e.*, incision, evacuation of calculi and drainage for the causative catarrh.

3. Gall-bladder enlargements in general call invariably for surgical interference.

Thus (*a*) the gall-bladder may become distended by calculi alone into a palpable tumor, and such an accumulation is a constant menace which may at any moment induce the different cholecystic and pericystic lesions about to be enumerated.

(*b*) The extrusion of a calculus into the cystic duct may completely block the same with a consequent hydrops. Both of these are distinct operative indications, although also largely preventive.

(*c*) Such a pyriform, fluctuating tumor may be an empyema, either primary or developing upon a hydrops or a calculous accumulation, and this always calls for surgical intervention. Hydrops, calculous enlargement, or even empyema, do not necessarily present a tender or painful tumor, although pain and tenderness below the rib-border are strongly suggestive symptoms.

(*d*) In consequence of pressure perhaps, but infection surely, such a distended gall-bladder may suddenly become locally or diffusely gangrenous, a condition which demands prompt surgical interference. These are cases which often simulate acute

appendicitis, especially when the tumor is large enough to approach the caput coli. The abdominal symptoms are often closely similar.

In connection with pressure necrosis, it is well to remember that calculi of large size, sufficient to produce the not infrequent variety of bowel obstruction due to gallstones, may work their way by pressure necrosis, adhesion to the neighboring intestine and ulceration into the latter without subjective symptoms of any kind, the first intimation of their escape being the obstruction or their presence together with free bile in the stools. This observation, as well as the frequent latency of gallstones, seems to substantiate the microbic origin of all pericystic lesions, beyond, perhaps, the above-mentioned adhesion of adjacent peritoneal surfaces. Typhoid bacilli can almost always be found in the gall-bladder after an attack of enteric fever, and the bacillus coli communis is a frequent inhabitant of the same. This is also true of the staphylococci and streptococci, and even intestinal parasites have found their way up this side-track.

4. The extra-cystic lesions of course belong to the realm of surgery. Thus we may have a peritoneal sepsis, especially with a gangrenous cholecystitis. Fortunately the diffusion of such a process is delayed by the isolation of the well-known subhepatic space, so that the infections give more time for limitation, just as do those from the appendix when that organ points upward and outward into the lateral abdominal gutter, in marked contrast with the rapidly diffusing infections when it points inward, or inward and upward, or even, to a less degree, it is true, toward the more slowly poisoned pelvis. Again, and this is more frequently the case, the peritonitis is limited, and an encysted pus accumulation results. This may be subhepatic, usually following the remnants of the umbilical vein and pointing at the umbilicus, showing itself anteriorly or in the loin, and occasionally as a subphrenic abscess. The treatment in any of the above conditions is self-evident. Lastly, there is the mildest type of peritoneal inflammation, the fibrinous, producing all manner and amount of adhesions. Such a condition may prove a sufficient source of pain and disability to demand surgical interference in the absence of gallstones, gall-bladder or duct-lesions. These adhesions not infrequently

involve the stomach and pylorus, and may even simulate disease of this viscus. I have met with one such case in which a suspicion of malignant disease led to exploration, the freeing of pyloric adhesions being followed by a complete restoration to health. Of diagnostic value in such cases is the observation that the paroxysms of hepatic colic begin on the left side, over the stomach, and thence spread to their usual location.

5. The common-duct stone is the one most frequently met with, either completely obstructing the bile-flow, or as the "ball-valve" calculus, which does so intermittingly. If such a stone occlude the duct before any mural lesions have developed in the gall-bladder, this organ will become distended with bile and mucus, but rupture does not take place, as the bile-stream is weak and is dammed back into the liver and the circulation. Usually, however, the gall-bladder is non-distensible; hence the observation that the organ is not palpable in common-duct stone. The other symptoms are jaundice and pain, either intermittent or continuous, the latter radiating toward the umbilicus, with tenderness at the so-called Mayo-Robson point, and the already mentioned paroxysms of chill, fever and sweat, which are said to be due to infective cholangitis. The latter statement I am inclined to doubt somewhat, in view of personal clinical observation. Infective cholangitis must sooner or later mean suppurative cholangitis, and the latter is usually followed by multiple hepatic abscesses. I have operated a number of cases in which these seizures had extended over considerable periods, in which there were no clinical evidences of infection, and certainly none of suppuration, which were not complicated by hepatic abscess, and which quickly recovered after cleaning out and drainage.

Far more rare are the cases of calculus obstruction of the hepatic duct, and I have met with but one, where eleven calculi were found and removed. In such patients there is the intermittent or continuous jaundice, and perhaps the chill, fever and sweat, with a non-palpable gall-bladder, of course. The pain, however, and the tenderness are higher up, and deep-seated as contrasted with the common-duct symptoms. It seems almost superfluous to add that all duct calculi not promptly expelled call for preventive, if not for curative, intervention, the only question for individual judgment being that of the persistence

of symptoms, and here I believe we should lean in the direction of early intervention. In the presence of a suppurative cholangitis, with its consequent hepatic abscesses, or of the chill, fever and sweat seizures associated with jaundice, whether they be deemed infective in origin or not, drainage is, in the former instance, the first step, and in the latter, the curative one.

6. There is a class of cases which present, as leading symptoms, chronic jaundice, recognized as obstructive in character and associated with enlargement of the gall-bladder, which excludes previous mural changes in this organ. Pain may be present, but is not striking or severe, and tenderness is usually absent. Such a picture presents malignant obstruction of the common duct, although I have found it due to adhesions, traumatic or even calculous in origin; in the latter instance the gall-bladder was contracted, although no stone was present, it having been expelled. In such cases the establishment of a biliary fistula, or a cholecystenterostomy, or even a cholecystocolostomy, naturally comes up. In cicatricial obstruction such procedures are thoroughly feasible; and, even if an intestinal communication cannot be established, the administration of ox-gall will prevent any interference with the general health from the loss of bile, the inconvenience of the leak being the only drawback. In malignant disease, however, my experience has been unsatisfactory, the indication being to divert the bile, or to establish a biliary fistula; but I have not found either plan satisfactory. Such patients do not stand the simplest operation well; the vent or side-track frequently does not relieve the jaundice; and as in every incomplete operation for malignant disease, the progress of the same seems at times to be hastened by an unsuccessful intervention. If, then, exploration shows inoperable cancer, we should frankly confess that at most the cholæmia may be lessened and life perhaps prolonged.

7. There are a certain number of cases in which we meet with fistulous openings, post-operative, traumatic or spontaneous, mucous, muco-purulent or biliary, in the region of the gall-bladder, its ducts, and the liver. Such cases are naturally purely surgical. In some, cholecystectomy is the cure; in others of a similar character the leak is best left alone; in others, again, intestinal anastomosis will carry away the discharge; and in still others, choledochotomy, or even choledoch-enterostomy, may

be called for. These are purely questions of surgical judgment and technique, and therefore require no further discussion here.

8. The same is true of stab, gunshot and contused wounds or rupture of the gall-bladder and its ducts, which naturally always demand prompt and intelligent surgical measures.

In conclusion, permit me to impress upon my medical colleagues, if my report and deductions are deserving of such "impression," that many cases of gall-bladder and gall-duct disease hitherto "tinkered" with medically should be more promptly, and, I might add, more intelligently, treated surgically. I flatter myself that, in a Society which has watched my work and listened to my papers for the past seventeen years, the conservatism I have conscientiously tried to preach and practice will be appreciated, and that I will not be accused of attempting to universalize the knife, but rather to indicate where surgery can best be the handmaid of medicine.

APIS MELLIFICA.

BY WESTON D. BAYLEY, M.D., AND I. G. SHALLCROSS, M.D., PHILADELPHIA.

(Read before the A. R. Thomas Club.)

It has been ingeniously said of Hahnemann and his immediate associates that they knew better the art of selecting the homœopathic drug because they had personally experienced the effects of many of them in proving. This is doubtless true, and it is with a sudden sense of inflicted conscience that the writer is constrained to admit that it is only in the solitary instance of this medicinal agent that he is qualified to appreciate the enhanced dexterity of those immortal pioneers; because he, too, has, in an humble and untutored way, proven *Apis mellifica*. Nor, upon reflection, can it be said that this statement goes down to the author's credit as an original investigator, since it must be honestly confessed that the several provings for which he can personally vouch were purely involuntary, and conducted according to the natural and unpremeditated hypodermic method familiar to and employed by the bees themselves.

To dwell upon these experiences carries the writer back to times long past, and brings up memories of innocent youth and health-restoring outings in the quiet but superbly beautiful Chester County, Pennsylvania.

Apis was first proven in the premeditated and orthodox way by Dr. Humphreys, of New York, and found to possess certain definite qualities calculated to render it a welcome addition to the real *materia medica*. These symptoms are to be found duly classified and tabulated in all of our drug books, so to tell of them here would be inexcusable repetition. To the writer, a drug dissected into rubrics is always suggestive of a kind of post-mortem—perhaps a necessary post-mortem; but, anyhow, the subject is cold, stiff and infected. Such an arrangement is useful for reference but wearisome for tête-à-tête.

If the genius of Apis could be expressed in a sentence, I would say that the trend of its action is upon peripheral vasomotors—an action stamped by a strong individuality.

Thus, in the skin we observe the pathographic simulation of Apis action to the neuropathic œdemas, accompanied, like them, with the peculiar itching and burning. This same condition, when diffuse or confluent, will resemble erysipelas; but, of course, no one in these days would depend alone on internal medication in this latter disease. In scarlet fever it is probably a remedy second in importance only to Belladonna; and in this connection must be remembered its effects on the kidney.

The mucous membranes, from the conjunctiva to the anus, express the sick-making action of Apis according to the peculiarity of their function. Generally speaking, there is œdema, erosion, exudation and watery effusion. Add this collective action to your knowledge of the function of any particular mucous membrane, and you can infer the more particular symptoms. In the viscera, the action is still vasomotor and inflammatory. It seemingly has produced meningitis, or at least acute brain œdema, with the familiar cerebral characteristics; and in brain affections Apis has enjoyed considerable reputation—with just what degree of reason, the writer, in spite of a considerable experience with brain diseases, confesses to be uncertain.

Reverting to mucous membranes, while still considering viscera, the diarrhœic conditions are of much importance. It

is sometimes of decided use in typhoid. In diarrhœas the stools are a greenish water, usually painless, and often involuntary. In fact a weakness of the puckering string, with its dramatic but unspeakable consequences, is a prime characteristic of *Apis*.

How rich, numerically, are the urinary symptoms! I wish it were possible to make a concise and rational statement regarding them. How badly we need microscopic and quantitative urinalysis in the provings of our renal drugs. In these days of pathologic and diagnostic acumen, anything short of a corresponding knowledge of drug-effect impairs our ability to set forth exact principles of prescription. In the matter of urine there is the double action—scanty, high-colored, suppressed; frequent, profuse and abundant. It is upon the former series that we most frequently prescribe, and they may be renal, *per se*, or a concomitant of some other local or general disease, among the symptoms of which there will usually be other characteristics of the drug. I would think of *Apis* where there were burning, itching surfaces co-existing with the passage of scanty, high-colored urine under conditions of tenesmus and irritability. As a diuretic, even under these conditions, its effects are not invariably certain, and it is just possible that failures are due to faulty preparations of the drug, or to our lack of knowledge of the best means of keeping active in our stock bottles its peculiar virtues. In the dropsical affections, particularly those of post-scarlatinal nephritis, it has a sphere of usefulness; but in the chronic dropsies and œdemas of serious cardiac or renal disease the writer has failed to secure any very definite results.

W. D. B.

The poison of the honey-bee “acts specifically upon the cellular tissue, giving as its most characteristic effect an acute œdema both of the skin and mucous membrane.” The general symptoms are those of great lassitude, with trembling, great drowsiness, extreme sleepiness; the patient is often absent-minded and indifferent, and is said to be very awkward. The pains are burning, stinging like the sting of a bee; they are decidedly ameliorated by cold applications. Thirst is usually absent during fever; fever is usually of a low type. Urine is scanty and high-colored as a rule, but may be suppressed. Albumin and casts are found by chemical and microscopical

analysis. In eye conditions we find the lids much swollen, red and œdematous, often everted, the upper lid hangs down like a sack over the eye. The conjunctiva becomes congested, puffy, œdematous, and full of dark-red, distended veins. Lachrymation is profuse, hot, and spurts out of the eye; the eyes burn from the watery discharge, and photophobia is quite marked; the pains are the characteristic, severe, sharp burning pains, with the sensation of a foreign body in the eye. In suppurative diseases Apis seems to be the remedy to use early, when abscess is threatened, but pus formation has not yet supervened.

In addition to the burning, stinging pains, there is a sensation of swelling or tension around the left eye. There is soreness of the lids and canthi, with agglutination, burning of the edges of the lids, causing lachrymation. Stinging in the ball and across the forehead, aching, pressing in the lower part of the eyeball, violent shocking pains over the right eye, extending down to the eyeball, smarting and sensation of burning in the eyes, with bright redness of the conjunctiva; stinging pains, dreadful shooting pains through the inflamed eye, sometimes throbbing, but burning and < on moving eyes or on exertion.

We consequently think of Apis in treating such conditions of the eyelids as *acute blepharitis*, either going on to abscess of the lids or not, when we have swelling and œdema of lids, with some redness or reddish-blueness, the characteristic stinging pains, profuse lachrymation, usually bland, and photophobia, absence of thirst and drowsy condition. There is often chemosis of the palpebral and sometimes of the ocular conjunctiva.

Right here it might be well to call attention to the use of Apis in *orbital cellulitis*. It is indicated early, before the formation of pus; when œdema is marked the patient is drowsy, there is present usually the characteristic pains, stinging and shooting.

Apis is also used in erysipelas of the lids, when we find the upper lid particularly œdematously swollen, and hanging down like a sack over the eye. The photophobia and lachrymation are very marked, the pains are characteristic, stinging and burning, and in addition there is a severe shooting pain over the eye, extending into the ball. The patient complains of a swollen feeling around the eyes and in the brows; he is drowsy

and thirstless, and is usually worse in the evening and forepart of the night.

Apis is sometimes useful in *acute catarrhal conjunctivitis*, the mucous membrane is bright red and puffy, lachrymation hot and moderately profuse, pains are characteristic; photophobia may be present; œdematous condition of the lids, particularly the upper, is usually present.

In *ophthalmia neonatorum* and *purulent conjunctivitis*, Apis is indicated when there is great swelling of the lids and adjacent cellular tissue. The conjunctiva is congested, puffy, and full of dilated veins. The discharge is moderate, not profuse, but lachrymation is well marked. The pains are stinging and shooting. The photophobia is marked, and symptoms are aggravated during early night.

In phlyctenular conjunctivitis, and also in membranous conjunctivitis, we may find Apis occasionally indicated when characteristic symptoms are present.

Various and severe forms of keratitis have been cured by Apis, although here its sphere of usefulness is quite limited. Keratitis, with dreadful pains shooting through the eyes, with swollen lids and conjunctiva, with photophobia, and hot lachrymation gushing out on opening the eyes, would call for Apis if the general symptoms of the drug were at all present. It may also be of use in pustular keratitis with chemosis, dark red conjunctiva and swollen lids, ulceration of the cornea, vascular with photophobia lachrymation and burning pains, lids everted and often ulcerated on the margins.

With its characteristic eye symptoms, Apis may be indicated in threatened panophthalmitis, or the early stages of that condition. We find Apis also advised in certain forms of retinitis albuminuria; but here the general and not the local symptoms should be consulted in prescribing, as our treatment should be directed to the kidneys, the seat of the primary disease.

All through eye diseases, the Apis patient is easily confounded with the Rhus patient. Objectively they are similar. Apis does not seem to control suppurative inflammations of the deep structure of the eye as Rhus does, though the puffiness of the lids might seem to indicate it; these cases are at first generally painless, and the external swelling is not bright red, as are the local and external troubles of Apis.

In differentiating the Apis from the Arsenic patient, we have, as a rule, in the latter drug a well-marked cachexia, and the discharges from the eye are not bland, as in Apis, but are acrid and excoriating; there is also a marked difference in the general symptoms.

Apis as a Throat Remedy.—Apis is indicated in diphtheria where there is prostration from the outset, fever is not high, pulse is rapid but not strong. The throat at first has a varnished appearance, the mucous membrane is a bright, glossy red in color. A membrane forms quickly on the tonsils, more often on the right, and has the appearance of wash-leather, being thick dirty grayish in color. The tongue is swollen so as to prevent swallowing, the patient complains of a fullness in the throat, which inclines him to swallow, but at the same time makes it very difficult. This is probably due to the œdema of the soft palate, uvula and tongue. In fact, the whole throat is œdematous—there are stinging pains extending to the ears when swallowing, and sometimes puffiness of the neck and face. The œdema may interfere with respiration, or we may have an œdematous extension to the larynx, followed by the characteristic membranous deposit. There is not much thirst. Urine is scanty, high-colored, burning and albuminous. In some cases a characteristic Apis rash makes its appearance over the body, and may at first make you think you have a case of scarlatina.

In former years Apis was looked upon as prophylactic of diphtheria; nowadays we are more inclined to trust to anti-toxin, both for a cure and as a prophylactic.

The general symptoms of Apis, plus the clinical experience of many homœopathic practitioners, mark it as one of the best, if not the very best remedy we have for erysipelatous inflammation of the mouth or throat. In acute catarrhal laryngitis, with œdema, no better remedy can be found; its action is quick and certain. In true œdematous laryngitis, whether the result of acute catarrh, traumatism, or acute nephritis, Apis is the first and most important remedy to think of. I have repeatedly seen the waxy, almost transparent appearance of the œdematous larynx subside without operative procedure under the beneficent action of Apis mell. Understand, however, I do not claim it as a cure-all; nor do I claim it will always take

the place of the scarifying knife or the tracheotomy tube, but many cases will respond to its kindly action.

Apis mellifica is a prince among the remedies used in the treatment of acute parenchymatous tonsillitis (quinsy), or even acute peritonsillar abscess; but here, as elsewhere in suppurative conditions, Apis should be used early, and only when indicated. If Apis is used when abscess threatens, before pus formation is accomplished, and when the throat has the characteristic œdematous swelling of the tonsil, soft palate, faucian arches, and uvula; when the patient complains of sharp, lancinating, burning and stinging pains shooting to the ear on attempted deglutition; if we have the characteristic external swelling (œdematous) at the angle of the jaw; if the patient finds it difficult to either swallow saliva or expectorate it on account of the pain; if, on account of the œdema, respiration is noisy or difficult, and even when œdema threatens to extend to the larynx, we examine our materia medica, we will find no better remedy, no greater similimum, and no drug that will give us a better result in a short time, than Apis. If we get our case late, when pus has accumulated and œdema has subsided, Apis is no longer our remedy. Hepar, perhaps, would give better results; but, given early, Apis will abort very many difficult, painful, tedious cases of tonsillar abscess. I believe it to be a much deeper-acting remedy in this class of cases than many of our materia medicas have been willing to acknowledge. I have never had marked results with it when used for follicular tonsillitis. In diseases of the ear and nose its action seems limited to erysipelatous inflammation of these organs.

I. G. S.

TREATMENT OF HAY FEVER.—In a discussion upon the above topic, reported in the *Medical Century* for last month, Dr. C. G. Fellows said he had frequently obtained good effects from *Chininum arsenicosum*, when the patient was much worse at night with the oppression of breathing; also for recurrent attacks. *Napthaline* had served his purposes well where there was a disagreeable wheezy hoarseness.

Dr. W. E. Taylor said he did not believe that pollen had anything to do with the disease. He believed that it was entirely of malarial origin. He had cured cases with *Natrum mur.*, *Eupatorium*, and *Arsenicum album*.

THE LIMITATIONS OF HOMŒOPATHY.

BY E. O. MORSE, M.D., FORT SMITH, ARKANSAS.

To be born in a country with the gift and privilege of free speech, and the right of expressing other than orthodox sentiments upon vital questions, whether pertaining to religion, politics or medicine, without being classed as a veritable heretic, is a privilege of which every American citizen should be proud—a privilege which he should unhesitatingly use if he is honest in his convictions, and can give clear and logical reasons for his diversity of opinion. It is only by such means, coupled with profound research, close observation and comparisons that the best results can be obtained in the solution of any difficult problem.

The object of this paper is, in as simple a way as possible, to portray the status of homœopathy, to outline its place in the medical world, and to reveal its limitations, as viewed by the writer, who believes the law of “*similia*” to be *one* of the best methods of curing the sick and restoring perverted functions to their normal condition with the aid of nature.

Probably at no period in the history of medicine has there existed in medical circles the harmony, not only among the best thinkers of the same school, but among the best men of different schools, as there is to-day. No doubt this is due to the fact that by their combined efforts certain facts, laws and theories have been so definitely proven (*e.g.*, those pertaining to chemistry, anatomy, physiology, pathology, etc.), that none but the most arbitrary could fail to accept them—leaving but the one bone of contention, “therapeutics,” over which there is still a scramble; and we will all hail the day when the lamb and the lion may lie down together (the lamb still remaining intact), and realize that the medical millennium has come. Then, and only then, in the eyes of the world, will medicine be truly called a science.

That there is such a law as *similia similibus curantur* no one can doubt who, in a fair-minded way, has allowed himself to investigate. Granting, then, that there is such a law, let us see

if it is universal. As the law of gravitation is universal and pervades all nature, yet modified by other natural laws to the extent that it stands out only as a factor in God's great plan of the universe, so the law of "similia" is universal in the animal world, but so modified by other physical laws that it, too, stands only as a factor in God's great plan of healing the sick.

Hahnemann should and will be immortalized for the great therapeutic light he let in upon the world, and he will ever stand as a benefactor to mankind; and while his master mind unfolded truths which will be handed from generation to generation, still he was but human.

There are those about us, and some who take upon themselves the responsibilities of moulding the minds of our medical students, who are guilty of worse than hero worship, yea, almost idolatry, who cling to the fallacious teachings of a man in his declining years, who accept his writings as the rule and guide of their faith, who go blindly on the *Organon*, the Bible of their professional life, oblivious to the truths revealed by modern research which, in Hahnemann's time, were but little understood, and which have proven conclusively the fallacies of some of his teachings.

I do not wish to be understood as denying them in toto, for he said many things that are as vital to homœopathy to-day as they were then. I contend that it is little less than sacrilegious, and, to say the least, anything but progressive, to accept, teach and practice the precepts entire of a man who lived nearly a century ago. For what but one Book has stood unrepudiated before the onward march of scientific investigation for even a quarter of a century, and whose teachings but those of Christ have not suffered a similar fate, whole or in part, in a like period of time? Those who accept the *Organon*, the *Chronic Diseases* and *Lesser Writings* of Hahnemann as the foundation of their medical temple are either ignorant of the world's progress or credit him with divine inspiration, or both, and at the same time stand in their own light and hamper the cause which they so tenderly espouse. Clearly to define and outline the limitations, or, rather, where the "law" is applicable and where it is not, is no easy task, and, of course, opinions vary.

But, from my observation, I feel free to say that aside from the few to whom my preliminary remarks refer, and who choose to call themselves "Hahnemannians," the tendency is towards rational medicine, and few will deny the inadequacy of our system to cope with certain diseases and meet certain emergencies that arise in the course of every physician's life. Admitting, then, that such emergencies may arise, and that you seek other than homœopathic methods to meet them, why not also seek a rational reason for this course, and in a logical way, from reading and experience, outline in your own mind *when* and *why* the law of similars is not applicable to a given case: thereby better fitting yourself and your student to fight the battles of your chosen profession. You owe this investigation to yourself, to your patient, and, above all, to homœopathy for its protection and perpetuation.

Many a shadow has been cast over homœopathy for a seeming failure to perform its function when the system was not at fault, but the stupid disciple of Æsculapius did not know that the law of similars was not indicated. I use the word *indicated* meaningly, for I believe there are times when homœopathy is not only *not indicated*, but when its use is a loss of time and a resulting danger to the patient. I will cite a few instances where, to my mind, the law of similars is totally inadequate, and should occupy no place in the mind of the physician until certain obstacles have been removed by radical means, whether mechanical, surgical or medicinal.

You are called to the bedside of a patient who is virtually waterlogged. He will tell you that he was well until a few months ago, when he began to notice shortness of breath, palpitation of the heart, etc., which rapidly grew worse, until he has finally become unable to breathe in the recumbent posture. A slight swelling in the ankles extended upward until the legs and arms are now swollen to twice or three times their normal size: the abdomen is distended, and the slightest exertion almost suffocates him. His urine has decreased to a few ounces per day. You examine the chest, and find an organic lesion of the heart, and rapidly dilating, and there are fine subcrepitant râles at the base of each lung. What does it mean, and what is to be done? It means that the man is drowning in the fluids of his own body: there is a leak in the hold, and the engine and pump

are crippled. What should be done? Spend hours of valuable time with Benninghausen, Lippe or Jahr's *Symptom Codex* in search of the indicated remedy? No! Homœopathy is *not indicated* for this condition of affairs any more than it is for coma from a depressed fracture of the skull, and is therefore not responsible for its failure if used. How much more rational to utilize the various means of draining the system of its load. The heart has proven itself incompetent, but elaterium, if properly given, will dispose of gallons through the bowels; jaborandi and hot pack will help through the skin; and digitalis, strophanthus or apocynum in physiological doses will aid through the heart and kidneys. What is the result? You first begin to realize that your patient is not so large as you thought he was, and he tells you that he breathes more easily than he has for months; there is a decided improvement in his general condition. Compensation is re-established; and now, if you are a good prescriber, homœopathy will do for you what our friends of the old school cannot do, viz., maintain the improvement you have gained, which they tell you was, at best, but temporary relief. Would the similar remedy, ever so carefully selected, have accomplished this if given when you first saw the patient, without the aid of other measures?

Again, you are called to a patient with a temperature of 107° , which was preceded by a terrific chill. He may be delirious or comatose, and perhaps has hematuria; what does it mean? It means the patient has pernicious malarial fever, and that the next paroxysm may be fatal. What should be done? Spend valuable time in the search and trial of a remedy which, granting its power if right, might prove to be the wrong one? No! Homœopathy is again not equal to the emergency, but acidulated quinine administered hypodermatically and in enormous doses, and properly repeated, will avoid another paroxysm; but the patient is not well, and again, if you are a good prescriber, the "similar" remedy will do more for him than can be done by any other method of selection.

Another instance: A patient comes to your office with the secondary manifestations of syphilis. Its fever is consuming him; every cell of his body is invaded, and shows the effect of syphilitic virus. His pains are unbearable, and his mind is in such a state that death is preferable. What does it mean?

It means that if syphilis in the secondary stage is allowed to proceed unchecked by radical means that its ravages will be unbounded, and that, sooner or later, there will be but one result. What should be done? Again lose valuable time in search of the "similar" remedy, and allow lesions to develop that are not amenable to any treatment? *No!* Give mercury in sufficient doses to arrest its progress, and give nature's healing powers the supremacy; then by the aid of your carefully chosen remedy you must expect a cure. But you may say that mercury is homœopathic to syphilis. I agree that it *may* be homœopathic to it, as any remedy may be; but can you point to any other homœopathic remedy that is universally a specific for a given disease? It cannot be homœopathic to *every* case of syphilis, because there are no two cases just alike. No, it is *not* homœopathic to syphilis, but a physiological antidote to the syphilitic virus, as quinine is antidotal to malarial toxemia. Neither, in the strict sense of the term, is curative, but a cure *may* result by the averted functions returning to normal through the antidotal effect of the two poisons; but usually pathological changes have taken place ere this has been accomplished, and they are amenable to the similar remedy. The storm has cleared away, but its effect remains, and here is where homœopathy has won its richest laurels; not in quieting the storm (this must be dispersed by other means), but in effectually removing the *débris*.

If a patient is poisoned, no matter whether by syphilis, malaria or strychnine, the poison must be antidoted, and the symptoms that remain yield readily to the similar remedy. If there is a mechanical or hygienical obstruction to the cure of the disease, remove it if possible, and if a cure does not ensue, you have at least brought it within the domain of homœopathic therapeutics. More harm has been done homœopathy by over-enthusiastic advocates expecting it to accomplish what is impossible than has been done it by its enemies.

The law of *similia* is universal but limited in its application. The most sanguine therapist would not expect the indicated homœopathic remedy to cure dysmenorrhœa from atresia without first dilating the os uteri; then why may there not be other mechanical obstacles to a cure yet unrecognized, as in the case of dropsy I cited, or morbid agencies, as in syphilis and malaria?

I leave this question to be solved in the private closet of your conscience, where you sometimes retire when the "indicated" remedy has failed and you are groping about in the dark, 'twixt humiliation and despair, for something to help you out of the dilemma. Is it not more honest in you, fairer to homœopathy and your patient, to seek a logical reason for your failure, and by mechanical, surgical, chemical or means what not, to prepare him for homœopathic medication?

EXTRACTS OF PAPERS READ AT THE SEMI-ANNUAL MEETING OF
THE NEW YORK STATE HOMŒOPATHIC MEDICAL SOCIETY,
SEPTEMBER 24-26.

BUREAU OF OPHTHALMOLOGY AND OTOTOLOGY.

Dr. J. L. Moffat read a paper entitled "Some Remedies for Otorrhœa," the substance of which is as follows:

When aural suppuration is once established, surgical procedures must be employed. To prevent suppuration, the prolonged application of cold (sometimes of heat) and often a free incision are invaluable measures. The tissues of the ears are as susceptible to drug action as are the similar tissues of other parts of the body. In August, 1892, a boy, ten years old, came to me for otitis media, suppurativa dextra of seven years' standing. Operation was out of the question, as he was white and anasarcaous. Hydrogen dioxide was used to keep the ear as clean as possible, and the main reliance was placed upon internal medication, the principal remedies being tellurium, kali sulph., kali phos., elaps and arse. iod. Progress was satisfactory but slow, slight recurrences requiring occasional attention at intervals of months for a couple of years, when he finally called himself well. Bryonia, arsenicum and gelsemium were necessary at times, and at last cardiac compensation was so well established that he experienced no bad effects from playing the violin and riding a bicycle. In chronic purulent otitis media I have had the best results, as to adjuvants, with hydrogen dioxide, electrozone, formalin, bichloride and succus calendula. Pulsatilla is good for profuse, bland, thick yellow or yellowish-green mucopurulent discharge of pus. Hepar is the first remedy usually

thought of for acute or chronic suppuration. Mercurius is suggested by pulsation of the pus at the inner end of the external auditory meatus. Thuja, if the patient has had gonorrhœa or has been vaccinated.

The condition of the naso-pharynx and Eustachian tube must always be taken into account, and the totality of symptoms should be covered, if possible.

BUREAU OF CLINICAL MEDICINE.

Dr. W. H. Nickelson read a paper on the "Clinical Excerpts of Echinacea." He related the following case :

In February, 1898, I confined Mrs. G., a primipara, who on the night of the fifth day, had a chill. The next day when making my regular calls, about eighteen hours after chill, found temperature 105° and pulse 140. Gave *ver. vir.* θ and irrigated the vagina and uterus. Temperature increased in six hours to 106° . No improvement for eighteen hours. Was given echinacea θ , ten drops every three hours, uterus irrigated every six to eight hours, and in twelve hours the temperature began to fall. In less than three days was normal and patient made rapid recovery. In a few other puerperal cases, when there has been any markable rise of temperature, I have used echinacea always with good results. I have never failed to see this remedy reduce the temperature and patient improve when the cause was septicæmia. In the suppurative stages of abscesses, carbuncles, and the like, it will reduce the fever, swelling and soreness, and hasten the healing.

Dr. Geo. F. Laidlaw read a paper on "The Treatment of Œdema," citing a case of an elderly man whom he once treated for general dropsy. Legs, abdomen and pleural cavity were full of water; œdema of the lungs; heart presented a mitral lesion with hypertrophy; urine scanty, thick and highly albuminous, only ten ounces being passed in twenty-four hours. Emaciation of arms and chest indicated dropsy to be of cardiac or hepatic origin rather than nephritic. Before coming under my care he had been treated by heart stimulation with strophanthus and free purgation with croton oil and elaterium.

I gave him small doses of digitalis and nitro-glycerin to steady a very weak and irregular heart action, and, in addition, my favorite diuretic, the borotartrate of potash. Twenty-four

hours of this treatment had no effect. I then gave a mixture of equal parts of tinctures of apis, apocynum and helleborus niger, of which ten drops is mixed with four ounces of water and a teaspoonful given every hour or so. Effect was prompt and satisfactory. Within six hours urine increased and became lighter in color, sleep, appetite and strength returned, and he was soon able to be about as a comfortable invalid. Non-inflammatory œdema is not a disease but a symptom, which means that the kidneys are not excreting enough water, there is some disease of the capillaries and lymph spaces of the affected part, and that there is a relative decrease in the solid constituents or an increase in the watery part of the blood. It is evident that, as far as visible damage to the kidney is concerned, the diuretic is less harmful than the purgative.

Dr. G. H. Jenkins read a paper entitled "Infantile Scurvy," in which he cited the case of a child, ten months old, plump and flabby, bottle baby, the only food having been malted milk. Slight rise in temperature, weak, constipated; had two upper incisor teeth; gums purple-plum color and swollen, foul breath. Hard swellings on the legs, just above the ankle joints. Seemed sore all over; cried hard when handled, as though in severe pain. Diet was changed on the first visit to thin strained oatmeal gruel and raw milk, with one-half to one teaspoonful of Trommer's extract of malt added to each feeding. Later, juice from raw steak was given in addition. The bowels were relieved by glycerin enemata, and child taken for an airing each day. Mouth swabbed with diluted listerine. Remedies, calc. carb., 6x trituration, and apis 12x. Improvement began at once and was continuous.

The disease is most common during the last half of the first and the first half of the second year. Faulty diet is the prime cause. It only occurs in babies fed on some form of prepared food, as malted, condensed or sterilized milk, or some of the many baby foods with which the market is flooded.

The patient is usually plump and apparently well nourished, but not really so. The first change noticed is in his complexion, which becomes pale and sallow, and the conjunctivæ pearly white. If the child has stood or walked, he no longer attempts to do so. The thighs are kept flexed and the limbs droop, in a condition of pseudo-paralysis. Swellings appear, which are

greatest above the ankle joints. There is not much fever and the temperature may be normal. The bowels are usually constipated and there may be blood in the stools. Scurvy is readily grafted upon rickets, and some physicians take the ground that every case of infantile scurvy is complicated by rickets and call the combination "Barlow's disease." The disease is very amenable to treatment, and a case properly treated shows improvement in a very few days. The diet must be radically changed. Raw milk, sieved potato, fresh fruit juice, as that of orange, and the juice of rare steak will be all-sufficient to effect a cure. But we have remedies at our command that hasten the cure. The calcareas, phosphorus and silicea, are most often indicated.

A paper was read by Dr. W. L. Love, entitled "Alopecia Areata," the substance of which was as follows:

Alopecia areata is a localized area of baldness, which begins suddenly upon an otherwise apparently healthy scalp. It usually appears first either at the top of the head or the parietal regions, although, in two cases I have treated, the margin of the hairy scalp at the back of the neck was first encroached upon. The condition may remain stationary or it may advance rapidly, these isolated spots coalescing until the entire scalp is involved—a young lady of twenty-five having lost every particle of hair on her head; the eyebrows were also gone. Many have considered it to be due to a vegetable parasite, but the predominant opinion is that it is due to a neurotic basis or a functional nerve trouble. Trichophytosis, or ringworm of the scalp, is most likely to be confounded with it, but in this trouble the hairs break off instead of falling out, and leave rough, uneven scales, while in alopecia areata the spots are smooth and well defined.

As to the treatment, phosphates should be given in the diet, and articles that make nerve food, as fish and fats. The treatment consists in stimulation by pure carbolic acid, which is rubbed over the affected surface and among the hairs surrounding the patch until the surface becomes white. This may cause a good deal of burning and irritation at first, but it soon wears off. In a week or so, exfoliation of the epidermis takes place; then the carbolic acid may be applied. Where a large surface is involved, sulphur ointment well rubbed in is useful, and

stimulating lotions, as quinine and zinc, or cantharides and capsicum, are applicable. Internal treatment has very little immediate effect, but it is of great importance in reference to an ultimate cure. At first the new hair comes in very white and fuzzy, but it finally comes in thick and brittle. The return to the normal is, of course, hastened by shaving the spots frequently after a little hair has grown.

BUREAU OF PÆDIATRICS.

Dr. J. G. Chadwick read a paper entitled "Ileo-colitis in Children."

Ileo-colitis is an inflammation of the mucous membrane of the ileum and colon, characterized by pain, tenesmus, and mucous bloody stools. There are three varieties of ileo-colitis: the catarrhal, the diphtheritic, the amœbic. Catarrhal dysentery may be acute or chronic, sporadic, endemic or epidemic. This disorder may occur at any age from birth to puberty, but is met with more frequently between the first and tenth year. Improper feeding seems to be the most potent etiological factor in these cases. The most frequent as well as the most powerful causative factor is improper feeding; the food may be faulty in quantity or quality, or in both. It occurs most often in babies who are artificially fed, although the breast-fed baby is not exempt. Sometimes the drinking-water will irritate the intestinal canal, regardless of whether or not the water contains harmful germs; sudden changes of temperature may, by chilling the body, cause dysentery. Bacteria may play an important part in the production of the disease. The lesions of catarrhal dysentery are important from a pathological point of view, and these lesions are usually confined to the lower part of the colon and rectum. Ulceration may take place. The ulcers at first are round and superficial, but soon enlarge, two or more coalescing and forming ulcers from one-half to one inch in diameter, often exposing the muscular coat of the intestine.

The onset of the disease is usually very sudden, preceded by fermented diarrhœa, and without any prodromal symptoms. The temperature is usually elevated two or three degrees, pulse is quickened, weak, and oftentimes compressible; strength becomes likewise diminished, and child quickly loses in weight and strength.

In the early stages it simulates acute intestinal catarrh; but when we get the characteristic stools of ileo-colitis, all doubt will disappear. In ileo-colitis the stools contain much mucous blood and perhaps small masses of fecal matter, usually having the odor one gets from "fresh meat." In acute intestinal catarrh the evacuations are usually much larger, and when blood is present it is usually in streaks, and not found mixed with mucus; the pain is much more intense and often paroxysmal; tenesmus is seldom present. The prognosis in the catarrhal form of ileo-colitis is usually favorable. The ordinary duration of the disease is from eight to ten days, but it may prove fatal in from twelve to seventy-two days. If ulceration be present, then the prognosis is unfavorable; when the discharge begins to diminish, and fecal matter again appears in the stools, together with a lessening of the nervous symptoms, then the prognosis can be considered good.

The preventive treatment of these affections consists in attention to all details of infant hygiene and the use of milk free from bacterial contamination. Some of my patients I have advised not to take milk that is sold in bulk from the milk-wagon, but I have had them use milk from the dairy where it has been pasteurized before coming into the city. The bowels should be thoroughly irrigated, using a fountain syringe with a soft rubber catheter attached, the latter passed into the bowels almost to its entirety, then using water that has been boiled with or without castile soap, or use a weak salt solution. It is wise to continue these irrigations until the return flow of water is perfectly clear. The diet must consist of liquid food from the very beginning. Aconite, if given early, is often able to cut short the trouble without any other remedy. If the case sets in with violent fever, aconite will many times cure the disease in from two to three days. Other remedies that could be thought of are aloes, arsenicum, baptisia, cantharis, merc. carb., nux vomica, rhus tox., sulphur, kali bich., ipecac. and colocynth.

BUREAU OF MATERIA MEDICA.

Dr. T. C. Duncan, of Chicago, read a paper on "Study of a Heart Drug," to the effect that "to study out a heart drug we must first be sure of our knowledge of physiology. Increased blood pressure from cardiac force or activity will disturb many

parts of the body, viz., brain respiration; kidneys, bowels, spine, etc. So we may have marked disturbance of the circulation and of other organs by a drug, and yet it not be essentially a cardiac drug. The bad news, while proving gelseminum, causing a diarrhœa, tells somewhat of its nervous character. It is also the case of a fever drug, with a relief through the skin, worse by respiration and by sleep."

BUREAU OF SURGERY.

Dr. Shirley R. Snow read a paper entitled "Care of the Alimentary Canal Before and After Operation."

After an operation has been determined upon, the sooner it is performed the surer we are of the results. It is a pretty well-established fact that the line of treatment for those who can wait should be as follows: The bowels should be opened by a mild cathartic or aperient water, and kept so for a week. The nourishment during this time should be highly nutritious, at the same time easy of assimilation. As much exercise as is practical should be taken. During the last twenty-four hours, all nourishment excepting liquids should be stopped. The morning of the operation a purgative enema should be given.

Emergency cases do not give us time for this careful preparation. Perhaps the most distressing symptom after the operation is thirst. This is difficult to relieve. Water may be given in small quantities, hot or cold, beginning ten hours after the operation; but it can be given earlier to cases that have had a cathartic. If the bowel has been emptied, normal salt solution will be absorbed more readily from the intestines, supplying, in part, the water required by the system. In the use of the enema a fountain syringe should always be used; if soap is added to the water it should not be too alkaline, the white soap being preferable. Enemata should not be used if the intestine has been wounded; an exception to this may be when the wound is high up, when a small salts and glycerin enemata may be used with caution.

During the first twenty-four hours, remedies seem to be of little avail in controlling vomiting. Absolute rest of both body and stomach seems to be the best treatment. As soon as the stomach will tolerate water, we should begin the administration of food. The nature and condition of the patient must be con-

sidered. Morphine should not be given except in cases in whom the nervous symptoms are so severe, or the pain is so intense, that it would seem best to secure rest with the hypodermic use of morphine.

Dr. C. E. Sawyer, of Marion, O., read a paper entitled "Where the Discrepancy?" to the effect that "the law demands of the physician that he shall spend from four to six years of the best part of his life at hard study, and when he is through he finds himself on a par with the commonest street vender of pills and proprietary prescriptions.

"The doctor bears the stamp of inequality. His liabilities are both criminal and civil. He is expected to guard the public interests by inventing means of preventing disease; still he is liable to be supplanted by the influence of the commonest town gossip; and not infrequently, when doing his duty honestly and earnestly, he becomes the subject of public ridicule. There are few vocations but have been awakened to the necessity of the times; but the doctor still trudges along in the same old way, without business tact or individual acumen. At first thought it might seem the laity alone were to blame, but a careful study of the details show that some of the greatest obstacles to professional advancement lie within the fraternity. The constant disagreement and bickerings among doctors themselves are the occasion of much belittlement. The general disposition to decry each other, to ridicule each other's schools, and to take exceptions to each other's plans of treatment, constitute within themselves the greatest source of injury. No doctor or college should admit as students other than educated men and women. With the numerous institutions of learning the country affords, medical students should have a college education. The policies of our medical colleges must be changed. Too many of these still think that it is necessary to verse their students in antiquated precepts, to teach them restricting dogmas and to school them in fossilized creeds. They have been taught by their Alma Mater to decry everyone else and everything else save he who, like himself, has been ground out of some special mill; and so long as such methods prevail we cannot expect other than discredit and disrespect from the laity. Up to the present time the medical fraternity has been engaged almost entirely with the physical causes

of disease. It has learned the origin of typhoid fever, of malaria, of consumption, of diphtheria, of scarlet fever, of measles, and numerous other conditions that menace the welfare of humanity. He has become perfectly familiar with organic changes and their phenomena, but so far he has left to the charlatan the development of the means to be used in dealing with functional disturbances and physical manifestations. The real way to overcome the influence and effects of these limited and one-sided forms of treatment is to educate people as to their real worth. It is not enough to simply belittle the principles of Christian Science, to ridicule Osteopathy, to throw mud at hypnotic influence, to decry suggestive therapeutics, or laugh at Dowieism; the means to be used against these over-estimated forces should be such as to demonstrate such merit as they possess, and to show without doubt the misrepresentation they make. One of the greatest shortcomings of the everyday medical literature is the fact that it does not reach enough of the laity. Doctors should write more for laymen, and medical literature should be more fully circulated."

BUREAU OF GYNÆCOLOGY.

Dr. A. R. Grant, of Utica, read a paper on "Sexual Neurasthenia."

These cases give a history of having been perfectly well until after the birth of the first, or, perhaps, second child, when a variety of symptoms develop. They have headache, dragging pains over the hips, numbness in the arms and hands; many have marked stomach symptoms, they become irritable and hard to get along with in the home.

In the early stage of this condition the patients sleep well, but complain of feeling exhausted in the morning; later, sleeplessness is a marked symptom. Frequent urination is present in one-half of all the cases, and they usually grow thin and anæmic. Physical examination of chest and abdomen is usually negative of organic lesion capable of producing any such group of symptoms. Pelvic examination gives the clue to the constant irritation which has been the cause of the nervous condition, undoubtedly by reflex action by way of the spinal ganglia and sympathetic plexus. There will be one or all of these conditions: Pain on bi-manual examination; a sensitive cervical tear; a heavy

uterus with endometritis, and possibly ovaritis or salpingitis; a cystocele or rectocele with relaxed vaginal outlet, which allows the uterus to prolapse or the fundus to assume a posterior position in the sacral hollow. From the os exudes a thick mucous discharge. This constitutes the fairly common condition irrespective of rectal affection. The treatment that is always gratifying and uniformly successful can be briefly stated; and it seems to make little difference whether the pelvic conditions have existed three years or thirty years, as far as practical results are concerned, except that the older cases are slower in reaching good health. Pelvic repair where the patient may have from two to four weeks of absolute rest; forced feeding, especially with foods rich in fats, commencing with very small amounts in the worst stomach cases, and rapidly increasing in quantity and variety. *Nux vomica* and iron are essential aids in attaining an increase in weight and nervous vitality.

BUREAU OF OBSTETRICS.

Dr. J. W. Sheldon, of Syracuse, read a paper entitled "Experience with the Use of Oxygen in Resuscitation of a New-born Infant."

"The mother of the infant, a primipara, was seized with puerperal convulsions during the second stage of a severe and tedious labor. Vigorous measures were used to meet this emergency. Forceps were applied, and every effort made to hasten delivery, which could not be effected as rapidly as I wished. Before it was accomplished five convulsions had occurred. Preparations were made for the resuscitation of the infant. Table was prepared, and everything placed in readiness, including hot and cold baths, instruments for withdrawing mucus or other substances from the respiratory passages. The child was born pale and limp, respiration was slow and imperfectly performed, and became slower until a gasp could be observed two or three times per minute. Muscular tone and reflexes were absent. Everything denoted a most alarming form of asphyxia. The usual means of resuscitation failed.

"Artificial respiration was utilized, in addition to the force of the liberated oxygen, to get into the lungs. Within a remarkably short time a change in the child was perceptible. The color of its face and lips first changed, pallor giving way to a

wholesome flush. Respiration was gradually re-established, the child grew warm, showed other signs of returning life, and recovered. It should be added that the mother, after suffering two severe post-partum convulsions within the first twelve hours, survived, and made a fine recovery."

A paper was read by Dr. De Witt G. Wilcox on "Sterility Among American Women." The author deplored the prevailing tendency among married couples to avoid children for no other purpose than the gratification of selfish desires. To such an extent has the evil grown that the average number of children born is less than two per marriage. Much as he deplored this evidence of degeneration in the race, he was even more emphatic in speaking of physical sterility, closing his paper with the following remarks:

The time allotted me is too brief to consider more than *one* of the causes of physical sterility, but that is the chief and most alarming cause, namely, gonorrhœal salpingitis. No one but the gynecologist knows what an important part this disease plays in the production of the reduced birth-rate. The family practitioner is cognizant of it in a general way, but unless he sees, as can be seen in hospital practice, from one to six women every day who are not only sterile, but who are miserable sufferers and semi-invalids from this pestilential disease, he can have but an inadequate idea of its prevalence and destructiveness.

Lamentable as it is to find such a number of victims of this disease, it is equally bad to learn that there is no cure for them, so far as the sterility is concerned. Were it only the prostitutes and abandoned women who were its victims, we might not feel it such a calamity that they could not reproduce their kind; but when it seeks out the fairest women in our land and enfolds them in its coils before they have known the sweet dream of motherhood, and while they are yet in the prime and vigor of sexual life, it shows not alone how deadly is its venom, but how widespread.

I endorse most heartily the proposed legislation in other States that no man should be permitted to marry unless he can show himself so absolutely free from all gonorrhœal taint as to preclude the possibility of infecting his intended wife. I wish we might agitate such legislation on our own State, for

gonorrhœa is an enemy whose destructiveness to the vitality and numerical strength of the State is as great, in an indirect way, as that of tuberculosis, and fully as worthy of a great effort at its utter annihilation.

MAXIMAL DOSES OF ATROPINE IN INTESTINAL OBSTRUCTION.

BY FRANK H. PRITCHARD, M.D., MONROEVILLE, OHIO.

FOR several months the *Muenchener Medicinische Wochenschrift* has been publishing cases of ileus of various degrees which have been promptly cured by atropine administered hypodermatically in enormous doses. Up to the present time about two dozen cases have been reported, out of which four have ended fatally. Several of these were not good examples of ileus. The use of belladonna and its preparations is by no means new, for various writers have been brought out and the dust rubbed off that we might see that they, in their time, recommended belladonna in ileus. But it was usually given along with morphine, or in insufficient doses, so that no very good results were obtained. The feature about the new treatment is in using atropine, beginning with a fair dose, about $\frac{1}{100}$ to $\frac{1}{50}$ grain, and if that be not enough, to *push the drug*, injecting even as much as $\frac{1}{20}$ grain at a time; one such dose is usually enough. The dangers of these maximal doses are not great, for no serious toxic symptoms have been reported. I have employed it in a case of intestinal occlusion, and that from a gallstone of the size of a small walnut, with good results.

A short time ago a farmer of sixty-two came to my office complaining of pain in his left hypochondrium, which radiated into the region of the navel. I examined him, but found neither hernia nor perceptible tumor in the abdomen. The next day he staggered down to my office (he resided in town), and though admitting that the pain was not quite so severe, he looked collapsed and pale; his tongue was dry and brown, his appetite gone, and he was quite weak. He had vomited several times a greenish-brown fluid which smelt and tasted like fæces. While trying to cough, at my office, he started to vomit, and threw up

about half a pint of a greenish fluid without odor. I ordered him to bed, advised hot poultices to the abdomen, starch enemata containing glycerin and turpentine every three hours, and gave him hyoseyamine diurnules every two hours. His pulse and temperature were normal; no flatus nor stool passed. The pains were paroxysmal and as they had been the day before. Seeing him at noon, I visited him at four o'clock in the afternoon, when he was about the same. He vomited twice while I was at his house, throwing up about two quarts of foul-smelling, feculent and greenish-brown fluid, with violent retching and choking. I injected $\frac{1}{50}$ grain of atropine, and gave him another enema. At eight in the evening I saw him again. His pains were less, he had not vomited, felt better, and had a more natural color. I then gave him about two ounces of olive oil, ordering him to take the rest of the contents of a four-ounce bottle during the night. I also gave him another hypodermatic of $\frac{1}{100}$ grain of atropine. The following morning I visited him, interested to know the result of my treatment. I found him weak but happy. He had had a hard stool, followed by several thin, foul and stinking ones, mixed with the oil. In the first one was a brownish-yellow gallstone as big as a small walnut, which probably had been the cause of the obstruction. I tried to saw the stone in two, but it fell into pieces under the saw. It consisted of a central "pit" of the size of a peach-stone, of a blackish color; the outer "shell" was of a brown color. It had a projecting portion on one side, and was irregularly marked.

Two years ago this patient had had a severe attack of gallstone colic, and though he was several weeks in recovering from the effects, being pale, weak, without appetite, and complaining of soreness about the gall-bladder, yet he fully recovered, and never had any pain since then until the occlusion came on. How this stone managed to get into the intestine without producing more pain than it did is to me inexplicable, unless it gradually ulcerated a way into the colon from the gall-bladder.

My patient lost fifteen pounds from his experience, and though up and around, he is still somewhat weak.

The results of the treatment by atropine were so immediate and satisfactory that I should feel like giving it a trial in such

cases which are at times the cause of a great deal of anxiety to us. The German literature reports very favorably on it. It would seem to be indicated in the dynamic variety of intestinal occlusion. We have all met with these. They are bothersome. I had one case in an old man of sixty-five, with an irreducible and uninvolved scrotal hernia of the size of a boy's head, and actually by count I gave and had given him, in the course of six days, seventy-five enemata. Finally, reaching around for help in any shape, I gave $\frac{1}{100}$ grain of atropia and calomel 1 grain every two hours. That night, towards morning, the belated passage started, and he was radiant the next morning when I visited him.

For several years I have employed atropine and morphine as an adjuvant in reducing incarcerated hernia. If one inject $\frac{1}{4}$ grain morphine and $\frac{1}{100}$ grain atropine into the immediate vicinity of the hernial ring and wait about half an hour, a hernia which is irreducible may often be replaced with ease. I have often frequently found this a useful aid, when miles from home at some distant farmhouse, with a patient suffering from an incarcerated rupture. The hernia seems to relax, and after some time it slips back.

To use Dr. O. S. Haines' way of putting a thing, it is a "good food-for-thought capsule" to be on the lookout for an incarcerated hernia or an intestinal obstruction whenever a patient vomits and complains of pain in the abdomen. They may be met with at times when the patient will not know that he has a hernia. One should not be content to ask if he has one, but only be satisfied after having looked.

GIDDINESS AND VERTICAL HEMIOPIA.—A man, aged 40 years, robust and rough, came to the dispensary in May, 1901, suffering from giddiness and vertical hemiopia. Symptoms: Reeling dizziness the whole day, as if from intoxication, especially in the morning, in the open air, when getting up or from rising when sitting; staggers when walking, with a sensation as if the front half of the brain whirled around in a circle; vertical hemiopia; objects are half invisible; other functions of the body well. This patient received *Titanium*, in small doses of the mother tincture, once a day, and, later, every other day. In twenty-three days he was perfectly cured.—Dr. Chakravati, in *Monthly Hom. Review* for September.

EDITORIAL.

THE URIC ACID DIATHESIS.

OF all the professions, the medical is the least bound by precedent. Indeed the characteristic of the new school of medicine, whose coming is so hopefully heralded, is the willingness to change, to surrender and condemn the truth of yesterday in order to adopt the novelty of to-day, and to repeat the process to-morrow. Many a physician has no other claim to what we would call notoriety, but which he calls fame, than his attempt to disprove some long accepted fact. While this has its disadvantages in rendering the basis of medicine insecure and indeterminate, it is in so far conducive to progress that it prevents stagnation, and furthers research irrespective of tradition and precedent.

There is a regular course which all theories are obliged to take in their passage from acceptance to rejection. They are at first advanced by the more progressive, the original thinkers and investigators of the profession, and then adopted by the profession at large in the order of their independence, until finally, before being dropped by all and handed over to the laity for their use, they are exploited by the drones and the least-informed practitioners, and used by them to economize thought and labor, while preserving a reputation for scientific attainment.

This has been the invariable course, especially of those theories which seek by generalization to trace the most varied collections of symptoms to some common cause. We can easily see how helpful such a proceeding becomes to the indolent as a labor-saving means of concealing ignorance. We need only refer to two of the most common as illustrations, namely, malaria, and eye-strain.

What a mass of ignorance does not the term "malaria" cover! How prolixly have not its protean aspects been enumerated, first by those who thought they had traced them to ma-

larial poison, but now by those who think not at all, but who find in them a useful sop to throw to the insatiable curiosity of the suffering laity, until now there is hardly an ailment under the sun which is not most happily disposed of by some doctor and by many of the public under its broad mantle.

Eye-strain, capable, indeed, of producing many symptoms near and remote, can hardly be held responsible for all the direful results which even yet are ascribed to it by many physicians, and to a much wider extent by the public at large.

A third theory to which we wish to draw attention at this time is the uric acid theory of disease. Ever since the discovery of uric acid in the form of a sodium compound in the blood of a patient suffering from gout, the most varied theories have been advanced as to the effects of uric acid in the blood, considered as a poison. To its presence have been ascribed not only gout, but headache, rheumatism, neuritis, meningitis, disseminated sclerosis, myalgia, hepatitis, nephritis, neurasthenia, arterio-sclerosis, insanity, hypochondriasis, hysteria, moodiness, irritability and bad temper, eruptions, uterine disturbances, sexual deficiency, pharyngitis, gastritis, enteritis, bronchitis, heart disease, asthma, and many other changes and symptoms.

Uric acid in the blood, lithæmia, too acid blood, uric-acidæmia, are words now used by the laity almost as widely as malaria, and with the same justification. It has been taught the terms by its medical advisers, and employs them as applicable to almost all the ills to which flesh is heir.

All the ailments mentioned above, and many others, occur idiopathically, and the only basis for a diagnosis of their dependence upon a uric acid diathesis is the real or supposed discovery of an excess of uric acid in the urine, and the false conclusion that, therefore, there must be an excess of this in the blood as their cause.

“Uric acid cannot exist as such in the blood; it can only be found there in the form either of the soluble but unstable quadriurate of sodium, or the less soluble but more stable biurate.”

“In the body fluids, uric acid is always found in the form of the quadriurate. In this form it is very soluble, and at the same time very unstable. When in contact with the sodium carbonate in the fluids of the body, the biurate is formed. This compound is very stable, and not very soluble, so that, when

found in excess in the blood or fluids of the body, precipitation occurs in the form of needle-like crystals, and concretions are formed in the cartilages of joints and in organs in which the precipitation takes place." (Dr. Frank Billings.)

It has lately been pointed out by Dr. C. Bartlett, in a paper on "The Clinical Relations and Diagnosis of the Uric Acid Diathesis," that the diagnostic value of the discovery of uric acid sediments in the urine depends entirely upon the associated clinical phenomena and the life-history of the patient. Such sediments, as he shows, are found where there is not necessarily an excess of the acid; they are very common in normal urine which has been allowed to stand for more than twelve hours; where the urine is highly concentrated or excessively acid; where there has been free indulgence in highly nitrogenous diet or in rich food; in cases where there is relative or absolute hepatic insufficiency; also in the profuse pale urine, with low specific gravity; in the neurotic and hysterical, where the absence of the usual urinary pigments tends to precipitate the uric acid. As he further points out, any deficiency in the oxidation-changes in the system causes an increase in uric acid deposits, which are accordingly found in connection with cardiac and respiratory disorders, and in cases of post-nasal adenoids; also in many liver affections, due here to deficient oxidation of waste matters.

The presence, therefore, of these uric acid sediments in the urine is not diagnostic of the condition called so frequently the uric acid diathesis, except where a careful examination reveals the presence of the essential characteristics of gout at some time in the history of the case, or a well-marked gouty ancestry.

We will not enter here upon a consideration of the various theories of the formation of uric acid in the body. Whether, as was long believed, it occupies an intermediate stage in the formation of urea in the liver, as a result of imperfect oxidation of the proteids, or whether, owing to imperfect metabolism of glycocin in the liver, it is the result of a union of this body and urea in the kidneys; or, finally, whether it is formed from the nuclein of the leucocytes and tissue cells by complete oxidation in the kidneys—our purpose will have been answered if we have succeeded in calling attention to the fact that it has become

necessary to revise the too-widely applied theory of the uric acid cause of disease, in consonance with the more exact methods of clinical and laboratory examination of recent years.

VACCINATION AND SMALL-POX.

IN the minds of the vast majority of physicians, there is no better established clinical fact than the ability of vaccination to prevent small-pox. With this view we are in complete accord. We note with regret that a class of agitators has arisen to oppose the practice of vaccination. Were the evil consequences of their folly visited upon themselves alone, we would have nothing to say. But inasmuch as they lead many of the unthinking into error and misfortune, it is our duty to protest against their fallacies with all the energy at our command. Many anti-vaccinationists are "anti" by nature. Many of them, if the opportunity offered, would be "anti's" of the "anti's." Like Pat, they do not care who constitute administration—they are against it. This opposition to vaccination is found in the ranks of both schools of medicine. We also find a growing class who think it shows mental greatness to be skeptical. They like to say, of any well-attested fact, "we do not believe in it," and so they say of vaccination. We know they do not mean what they say. They simply try to be smart. The arguments advanced against vaccination may be summarized as follows:

1. Vaccination is not a preventive of small-pox; it does not even mitigate the severity of the disease.
2. Its practice introduces an unhealthy virus, capable of unlimited ill-effects, into the system.
3. Vaccination produces tetanus, erysipelas, cancer, etc.
4. Vaccination is syphilis.
5. Vaccination owes its popularity entirely to the fact that it puts money into physicians' pockets.

To any one who has studied medical literature with unbiased mind, these objections must be regarded as either untruthful or silly. Indeed, were it not for their influence over the wavering and inexperienced, we would think it unnecessary to con-

sider this subject editorially. The present spread of small-pox in various parts of the country shows conclusively the necessity for some decided action. Especially should we, as homœopaths, place ourselves on record. Hahnemann believed in vaccination as a preventive of small-pox. He furthermore expressed as his opinion that the preventive influence of vaccinia over variola was an example of the homœopathic law. Evidence to this effect is presented in both the *Organon* and the *Lesser Writings*.

The method of argument pursued by some anti-vaccinationists sometimes savors of "yellow" journalism. Take, for example, the head-lines of a wall-chart, illustrating a lecture by an anti-vaccinationist of world-wide fame: "Awful depravity. Naughty Leicester. Shocking results following the refusal of the Leicester authorities to obey the compulsory vaccination laws of England." Then followed the statistics, of which we shall have more to say. Later, the lecturer announced his ability to cure any severe case of small-pox within six days; and a mild case in three days. He would not divulge his method yet, etc. He furthermore said vaccination was syphilis of the cow, transmitted to the human being. To prove his point, he exhibited illustrations of a sloughing chancre and of a sloughing vaccine sore, and remarked that their appearances were identical. How supremely ridiculous!

Taking up the first and the most important objection to vaccination, namely, that it does not protect, it is important to consider what small-pox was, prior to the introduction of vaccination, and, secondly, to study the clinical evidence in favor of its preventive influence.

As to the ravages of small-pox in pre-vaccination times, we cannot speak to better advantage than by quoting Macaulay. "The havoc of the plague had been more rapid; but the plague had visited our shores only once or twice within living memory. The small-pox was always present, filling the church-yards with corpses, tormenting with constant fears all whom it had not yet stricken, leaving on those whose lives it spared the hideous traces of its power, turning the babe into a changeling at which the mother shuddered, and making the eyes and cheeks of the betrothed maiden objects of horror to the lover." Statistics demonstrated that fully two-thirds of all children born

were sooner or later taken with small-pox, of whom about one-eighth died. The average annual death-rate from small-pox in England was 3000 per million of population.

Note the change at the present day! Whereas small-pox formerly attacked children, now, by reason of the better protection afforded by the efficient vaccination at that time of life, the majority of cases are in adults. That this change is not a mere coincidence is attested in certain localities where the vaccination of infants has been neglected, the old state of affairs returning. Gloucester was at one time the best vaccinated city in England, but for some reason the practice was neglected, and an epidemic of small-pox appeared. Dr. Sidney Coupland's investigations demonstrated the following:

Of the children in the city under 10 years, there were attacked:

26 vaccinated, of whom 1 (or 3.8 per cent.) died.

680 unvaccinated, of whom 279 (or 41 per cent.) died.

Of persons over 10 years of age, there were attacked:

1185 vaccinated, of whom 119 (or 10 per cent.) died.

88 unvaccinated; of whom 35 (or 39.7 per cent.) died.

If vaccination is a true prophylactic, the diminution in the number of children attacked is just what we would expect, for they have been more recently protected. We know that until within a very short time past the vaccination of new-born infants was a routine measure, this operation, in some sections of the country, being considered as part of the services rendered by the accoucheur, and included by him in his confinement fee.

Coming more directly to the statistics, and taking those obtained in localities where the anti-vaccinationists have made their boasts.

There is "naughty Leicester," so-called. In the epidemic of 1892-93,

Of children under 10 years of age, there were:

Vaccinated cases, 2; deaths, 0.

Unvaccinated cases, 107; deaths, 15 (or 14 per cent.).

Of persons over 10 years of age, there were:

Vaccinated, including doubtful cases, 197; deaths, 2 (1 per cent.).

Unvaccinated, 51; deaths, 4 (7.8 per cent.).

Arranging the cases in the same town according to the severity of the attacks,

Of the 199 vaccinated cases :

17 or 8.5 per cent. were confluent ;
20 or 10.1 per cent. were coherent ;
50 or 25.1 per cent. were discrete, and
112 or 56.3 per cent. were mild.

Of the 158 unvaccinated cases :

79 or 50 per cent. were confluent ;
36 or 22.8 per cent. were coherent ;
28 or 17.7 per cent. were discrete ;
15 or 9.5 per cent. were mild.

It is useless to multiply statistics, for one and all teach the same lesson. Space forbids quoting further details. Those interested in the subject may consult the *Reference Handbook of the Medical Sciences*, Allbutt's *System of Medicine*, the *Twentieth Century Practice of Medicine*, to say nothing of numerous other text-books. We cannot recall one medical author of prominence who has taken an anti-vaccination position.

Let us here refer to an incident not taken from medical literature. When the Rev. Henry J. Van Lennep, the eminent Presbyterian author and missionary, and father of our Dr. Wm. B. Van Lennep, was in Asia Minor, the town of Tocat was being decimated by small-pox. Mr. Van Lennep imported some vaccine, and with it vaccinated his son. From the scabs thus obtained he vaccinated thousands of natives, not one of whom contracted small-pox; and thus in an incredibly short space of time he stamped out the disease.

It was claimed by the anti-vaccinationists that the division of cases into two classes, vaccinated and unvaccinated, is unfair, as the unvaccinated are for the most part sickly children; hence the failure to vaccinate them. Investigation shows such not to be the case.

The greatly diminished incidence of small-pox has been explained by them as due to increased sanitary knowledge among the masses. Analysis of facts do not bear this statement out. In the case of cholera, typhoid fever and typhus, sanitation has done great work as a preventive factor. But not one of these diseases is analogous to small-pox in its mode of spread. Rather we should compare the spread of small-pox with scarlatina, measles and whooping-cough. Increased sanitary advantages should lessen the incidence of all these diseases equally. We find, however, that small-pox mortality has de-

clined 72 per cent., measles 9 per cent., and whooping-cough but a little more than 1 per cent.

Again, what better evidence do we want than the immunity of physicians, nurses and others in small-pox hospitals. Do we find the same classes possessing an equal degree of immunity against the other infections? A study of statistics shows the deaths of medical men from small-pox to be thirteen per million, as against seventy-three per million of the general population; whereas, in scarlet fever, against which doctors have no special protection, there is the remarkable fact that fifty-nine medical men per million die from this cause, as against sixteen per million of the public.

As further explaining the occurrence of small-pox in those who have been vaccinated, we find that this little operation is performed in a routine manner, and that oftentimes little or no effort is made to determine its success. Even when such attempts have been made, the presence of a "sore arm," or, as it has been called, "pseudo-vaccination," has been accepted as the real thing.

The second objection to vaccination is that it introduces an unhealthy virus into the system. It does introduce a virus into the system; but that it is unhealthy remains to be proven. That carelessness on the part of the operator may bring about dire results is certain; that carelessness on the part of the manufacturer will do the same is also certain. But no physician should permit himself to be careless, and we believe that very few physicians do. As to the manufacturers, they have too many millions of dollars invested; and competition is so keen that any laxity would be discovered by physicians, who will not hazard their good names by using such deleterious stuff. The same dangers apply to even greater degree to the eating of animal foods, the safeguards surrounding the preparation of which are nothing like as thorough as those used by the manufacturers of vaccine and serums. The anti-vaccinationist will finally say "vaccine is dirty, anyhow." When we think of the many millions of humanity who expose themselves voluntarily to the viruses of the venereal diseases for the gratification of animal instincts, this objection loses much of its sentiment.

The third objection to vaccination is that it produces numer-

ous diseases, of which erysipelas, cancer and tuberculosis have been specifically instanced. Erysipelas can, of course, follow vaccination, as it can any other wound. If, however, the operator observe due care, and if the subject is guilty of no indiscretions, such an accident is of the greatest rarity. And this, to our mind, is practically the only danger arising from vaccination. When one thinks of the many thousands vaccinated, and the very few cases of erysipelas arising therefrom, he must feel the insignificance of this evil as compared with the one it is intended to avert. The other diseases alleged to arise from vaccination arise from that cause with such rarity as to make the relation of cause and effect exceedingly problematical. Take tetanus, for example. Of five million vaccinations in England, there was but one case of tetanus. Had that disease been inoculated with the virus, it is morally certain that others upon whom the same grafts had been employed would likewise have suffered. In the rare cases in which tetanus followed vaccination there can be no doubt that the poison was introduced through some other medium than the vaccine virus. Again, as to the transmission of tuberculosis and other diseases of cattle. Attempts made to transmit tuberculosis in this way have signally failed. Even though it were possible to so transmit tuberculosis, is it conceivable that carelessness would be permitted in view of the many precautions adopted by the manufacturers, with their millions invested in the industry, their well-paid bacteriological experts, and the practical trial of their products by the thousands of physicians in the land, each of whom may damage his reputation irreparably should bad virus be used? The spread of cancer has been attributed to vaccination. Now, the only increase in cancer relates to the internal disease. External cancer is no more frequent than it ever was. We know that internal cancer is more frequently diagnosed; but so it ought to be, with the increased diagnostic skill of the present day.

That vaccination is syphilis is too absurd to be considered. The arguments advanced in its favor remind us very much of cuttlefish tactics.

That vaccination is opposed to homœopathy we deny. Sufficient reason for our denial is found in the facts and in the writings of Hahnemann.

In the introduction to his *Organon of the Healing Art*, Hahnemann says :

“Can vaccination protect us from the small-pox otherwise than homœopathically? Without mentioning any other traits of close resemblance which often exist between these two maladies, they have these in common: They generally appear but once during the course of a person’s life; they leave behind cicatrices equally deep; they both occasion tumefaction of the axillary glands and fever that is analogous; an inflamed areola around each pock; and, finally, ophthalmia and convulsions. The cow-pox would even destroy the small-pox on its first appearance; that is to say, it would cure this already existing malady if the intensity of the small-pox did not predominate over it. To produce this effect, then, it only wants that excess of power which, according to the law of nature, ought to correspond with the homœopathic resemblance in order to effect a cure. Vaccination considered as a homœopathic remedy cannot, therefore, prove efficacious excepting when employed previous to the appearance of the small-pox, which is the stronger of the two. In this manner it excites a disease very analogous, and consequently homœopathic to the small-pox, after whose course the human body, which, according to custom, can only be attacked once with a disease of this nature, is henceforward protected against a similar contagion.”

That vaccination would die out but for the money it gives the physician is a base slander on a noble profession. There may be physicians who are capable of doing a dishonorable action, but *we have never known one who would even entertain the idea of impairing the health of one of his patients, or of keeping a patient sick one day longer than necessary, for the purpose of making additional income for himself.* On the contrary, physicians are the most unselfish persons in the world. There is not one who would not be willing to banish disease from the face of the earth, even though by so doing he would deprive himself of his means of earning an income.

To conclude, we again express ourselves in favor of vaccination as a preventive of small-pox; we believe it to be a preventive subject to no danger, excepting in the hands of the ignorant and careless; that, if it were more generally practiced, small-pox would become a thing of the past. We believe it to be the duty of all physicians to propagate these truths among the laity, and to see to it that those who entrust themselves to their care are properly protected against humanity’s scourge—small-pox.

GLEANINGS.

THE THYROID TREATMENT OF DISEASES OF CERTAIN CHILDREN, AND ESPECIALLY OF BACKWARD CHILDREN.—At a recent meeting of the Pediatric Society of Paris this question was discussed. Dr. Guinon thought that not only were disturbances of the thyroid secretion causes of defective development, infantilism, but also that it might be due to chronic infections, as tuberculosis and malaria. Still other important factors were changes in the blood-making organs. Whatever be the cause, whether the thyroid gland be found to be affected or not, thyroid feeding is indicated.

Dr. Variot praised the effects of thyroid preparations in cryptorchismus. In classic myxoedema, as well as in corpulency, it often does wonders. Its indications are now firmly settled.

Dr. Apart declared that thyroid preparations act upon metabolism and the testes especially. He cited the case of a child, who after having been thus treated for eleven months, the testicles began to descend, for one may be felt deep in each inguinal ring, where previously none could be detected.—*Muenchener Medicinische Wochenschrift*, No. 30, 1901.

Frank H. Pritchard, M.D.

TREATMENT OF BEGINNING CATARACTS BY COLLYRIA AND LOCAL BATHS OF SOLUTIONS OF THE IODIDES.—Prof. Badal, of the medical faculty of Bordeaux, noting the facility with which the eye absorbs solutions of the iodides, has, for some time, been using collyria and eye-baths of 2.5 per cent. solutions of either the iodide of sodium or potassium. One to two drops of the solutions are instilled morning and evening; or the same is applied by means of an eye-cup, for one to two minutes, against the half-open eyes. Without having noted that a cataract has been wholly absorbed, he has been so fortunate as to have caused several to be arrested and the greater number to have developed quite slowly, much more so than is their custom. Admitting the irregular development of cataracts, yet having had these cases under treatment for eighteen months to two and a half years, and the fact that they remained in many cases stationary, he gives the credit to the remedies. Either the iodide of potash or sodium may be employed.—*Le Semaine Médicale*, No. 31, 1901.

Frank H. Pritchard, M.D.

NEURALGIA AND LATENT ANEURYSMS OF THE AORTA.—Prof. H. Huchard, of Paris, referring to the ease with which an aneurysm of the upper portion of the aorta, both within and without the pericardium, may be recognized by its symptoms of pressure on neighboring organs, directs attention to the difficulty or even impossibility of making a diagnosis where it is situated below the left bronchus. With true French spirituality he calls this "the latent zone of misunderstood aneurysms." The aneurysm grows deeply and does not come into immediate contact with organs which produce symptoms; and it may be said of these, what Laennec stated to be true of *all* aortic

aneurysms, that its first sign is the patient's sudden death. He dwells on the fact that a neuralgia is often its most apparent symptom, and he cites numerous examples. Ten years ago he held a consultation with Charcot in a case of obstinate neuralgia of the left arm. Charcot asserted that "he knew of no neuralgia so persistent as a brachial one;" later in this case Huchard detected an aneurysm of the subclavian. Two years ago he reported the case of a patient who suffered from a very violent right-sided intercostal neuralgia from an aneurysm of the left axillary artery. In 1871 he observed an aneurysm of the thoracic aorta which nearly filled the left half of the thorax; the chest was punctured and about two pints of fluid evacuated, the trocar fortunately missing the aneurysmal sac; but the patient died shortly after of asphyxia. The chief symptom had been a distressing intercostal neuralgia which for the last eight months of life had been regarded as of pleuritic origin. Prof. Potain has observed a similar case.

Abdominal aneurysms may also give rise to neuralgic symptoms; they may be continuous or paroxysmal, localized in the lumbar region or round about the trunk, with irradiation into the sacrum, ureters, testes, etc., so that the patient only feels relieved by lying on his belly.

Hence if one have to do with a case of violent and persistent pains dependent on the patient's position, one should think of aneurysm and have him skiagraphed, the only certain means of ascertaining. He reports a case where neither the examination of the pulse, nor sphygmographic nor cardiographic curves, led one to think of such a condition, yet where radioscopy revealed an aneurysm which was cured by large doses of the iodide of potassium (5-8 gms. a day) with simultaneous administration of the glycerophosphate of lime, to increase the patient's tolerance. The tumor decreased in size and the pains disappeared. The patient was also put on a milk diet.—*Journal des Praticiens*, June 8, 1901.

Frank H. Pritchard, M.D.

AN EPIDEMIC OF POLIOMYELITIS ANTERIOR ACUTA.—Dr. Leegaard, of Christiania, admitting that this disease is generally accepted as infectious, whose epidemic appearance has at times been noted, points out those observed by Medin, of Stockholm, in 1887 and 1895, which were carefully observed and were extensive. Leegaard has passed through an epidemic of fifty-four cases, of which he personally saw four, while the local physicians observed the rest. Of these cases two died, twelve recovered, ten greatly improved, and thirty remained invalids; therefore the disease may be said to have been quite malignant. He assumes the epidemic to have been dependent upon a specific infection whose greatest vitality was from July to October, diminishing during the winter months, when it died out. He succeeded in showing how infection was transmitted slowly or rapidly according to facilities for intercommunication, and was spread in an unknown manner. It probably gained entrance to the system through the digestive tract, as witnessed by the numerous gastric symptoms at the beginning, with possible predisposing factors—for example, age; for the first four years of life were especially prone. Children of a later age and youths were less affected, while chilling and overexertion aided. The stage of incubation only lasted a few days. The disease began with slight febrile symptoms, and pains in the head, back and extremities, which were radiating and very severe; paralysis would follow in two to three days, to

develop more extensively in the days following. It was gradually ascending, and may be of very varying extent, and involve from one muscle or group of muscles to all muscles. The lower extremities were most often affected; then, second in frequency, the upper. The paralyzed limbs were flabby, the reflexes absent, while atrophy and the reaction of degeneration soon appeared. Improvement set in within a few weeks and gradually progressed, usually, however, leaving a decided grade of invalidism. On account of the ravages of this disease in previously healthy persons he would isolate such patients for three weeks, and afterwards thoroughly disinfect.—*Norsk Magazin for Laegevidenskaben*, No. 4, 1901.

Frank H. Pritchard, M.D.

RECTAL INJECTIONS OF COLD WATER IN TYPHOID FEVER.—Prof. Lémoine, of Lille, France, admits the value of cold-water baths in typhoid, yet in those cases where this method cannot be carried out advises the use of rectal injections of cold water. He boils and cools the water to 18–20° C., for fear of causing painful griping and possible perforation of the bowels. They are given every three hours by means of a fountain syringe, injecting two quarts each time, quite slowly, with a care to interrupt the flow from time to time, in order not to distend the bowel too much. These injections lower the temperature better than the baths, but their action is not so lasting, for the maximum is reached in twenty to thirty minutes, and the fever reaches its former height in an hour after the injection. In spite of this, the patients treated thus have in general a lower temperature, which remains steadier and pursues a more regular course; for the injections not only reduce the temperature, but flush out the whole of the large intestine. The patient lies on his back and the tip of the tube is introduced twenty cms. In thirty-two cases of typhoid the results were good.—*La Semaine Médicale*, No. 33, 1901.

Frank H. Pritchard, M.D.

THE PROGNOSTIC IMPORTANCE OF ASCITES WITH ABDOMINAL TUMORS.—Prof. Frits Levy, of Copenhagen, directs attention to a kind of ascites accompanying not only peritoneal tuberculosis, but chiefly malignant growths of the uterus and its appendages, where the case impresses one as almost hopeless, yet where operative interference will in many cases bring about a radical cure. He has observed three such cases. The first, a peasant's wife of fifty-two years, multipara, was operated on February, 1888. During the preceding two years she had noticed her abdomen increase in size so that she suffered from difficulty in breathing and digestive disturbances. Her abdomen was punctured and about fifteen liters of a clear, yellow fluid withdrawn, when a large and firm tumor, thought to be malignant, was made out. The ascites rapidly reappeared, so that during the following two years she was often tapped—about every one to two months. Her strength greatly decreased, she looked more and more cachectic, so that not only she herself but her friends regarded her case as hopeless. When the writer first saw her, in 1887, he was of the same opinion; but in time she became so tired of the endless tapping that she urged an operation, which was done February, 1888. The tumor, round, firm and massive, reached slightly up above the umbilicus, and was found to be a fibro-sarcoma, originating in the left ovary. The operation was not difficult; the patient rapidly recovered, and has remained in good health since—thirteen years.

The second, the widow of a minister, nullipara, slight in build and delicate, with an enormously distended abdomen, was first seen in 1891. Paracentesis withdrew ten liters of clear, yellow fluid, and revealed two hard, nodular growths of the size of one's fist in the lowermost portion of the abdomen. Not only her physicians but also she herself refused to consider an operation, as she was so cachectic and weak. The fluid was quickly reproduced, so that in 1891 paracentesis was done every six weeks; in 1892 oftener, until scarcely three weeks passed without it being necessary; in 1893, at times, the periods lengthened, but rarely longer than eight weeks; and in 1894 they were more frequently required. During all these years, in spite of the enormous loss of fluid, she did not grow weaker. A few days after tapping she could walk out and eat with good appetite, while all her functions were in order. In August, 1894, she proposed an operation, which was done a few days before her eightieth birthday. Two sarcomatously degenerated ovaries were removed; she recovered excellently. She now lives in the best of health, without a trace of ascites. During the preceding years she had been tapped thirty-seven times and had lost about four hundred liters of fluid, quite a quantity for a person weighing about eighty pounds.

The third case was that of an unmarried woman of forty-five years who during the summer of 1899 was treated for various symptoms apparently due to an intestinal catarrh. In the fall she noticed her abdomen growing larger, and quite a degree of ascites was detected. About eleven liters of a yellowish and oily fluid was evacuated, and no tumor beyond two nodes of the size of an egg were to be felt in the true pelvis. The ascites rapidly re-formed, so that when laparotomy was done ten days later, about eight liters of this same fluid flowed out. The peritoneum was smooth and shining, injected in spots, with small and granular masses on the mesentery and small intestines, as well as in spots scattered about the serous surfaces. Both ovaries had degenerated to hard, nodular masses, which, seemingly without pedicles, grew from the broad ligaments. The operation was quite difficult, as the ligaments and connective tissues had to be removed as much as possible. After the operation the patient was quite collapsed, vomited a great deal, and suffered from meteorism, but there was neither fever nor reappearance of the ascites, and after a long and tedious convalescence she was restored to health. Since then, though the tumors were seemingly malignant, she has remained in good health. Of course a recurrence is not yet impossible. Such cases deserve operation, for it is their last chance, and the results are liable to be satisfactory.—*Hospitalstiftende*, No. 31, 1901.

Frank H. Pritchard, M.D.

THE PROGNOSIS OF ASCENDING GONORRHOEA IN WOMEN.—(Krönig).—Dissatisfied with the results of operative treatment for gonorrhœal diseases of the appendages, Zweifel has refrained from operating, even in severe cases, to make a closer study of the disease. Krönig has followed thirty-eight such cases with conservative treatment for three years, and re-examined them at the end of that period. Thirty-two of them were perfectly able to do their usual work. The danger of peritoneal inflammation has been overestimated. None of the thirty-eight cases had become pregnant, but a comparison with other cases showed that while relative sterility was increased, it was not necessarily absolute.

Krönig expresses the opinion that even cases of large pyosactosalpinx will improve with medical treatment, and that operative treatment should be employed only very rarely, as freedom from distressing symptoms is not insured by it. In over 90 per cent. of the cases in working women the prognosis of the expectant treatment is so good that operative measures are not warranted. In over seventy-four cases of ascending gonorrhœa there was no death.—*Centralblatt für Gynäkologie*, No. 28, 1901.

George R. Southwick, M.D.

THE TREATMENT OF CHRONIC EXUDATES IN THE PELVIS BY HOT AIR.—(Polano.)—The writer has employed hot air after the manner in which it is used for rheumatic arthritis with marked success. It is not so helpful for salpingitis as for cellulitis. Large exudates have disappeared very rapidly. A hard-rubber vaginal speculum is inserted to allow the hot air to enter the pelvis, and the pelvis and abdomen are encased in a hot-air chamber. The duration of the treatment is from one to three-quarters of an hour. Except profuse perspiration and a slight prickling of the skin, no discomfort is experienced from the extreme dry heat. All the usual precautions must be observed.—*Centralblatt für Gynäkologie*, No. 30, 1901.

George R. Southwick, M.D.

THE OPERATIVE TREATMENT OF PYOSALPINX.—(Mandl and Bürger.)—The writers have made a careful report on the subject, based largely on the material of Prof. Schauta's clinic in Vienna. They sum up as follows:

1. All peritoneal operations for pyosalpinx, all things equal, should be vaginal.
2. In bilateral pyosalpinx the bilateral salpingo-ovariotomy abdominalis is not performed in this clinic. The operation has the disadvantage of laparotomy, and the permanent results are not satisfactory.
3. Unilateral extirpation of a purulent appendage by laparotomy is only admissible when the disease is confined to one side and the opposite side is healthy. This may be determined by waiting for a considerable period, or exploratory puncture to determine the sterility of the pus.
4. The abdominal radical operation is reserved for those cases where removal of the diseased organs by the vagina cannot be performed.
5. The vaginal radical operation is the operation of election for purulent disease for uni- or bi-lateral pyosalpinx. It gives the best immediate and permanent results.
6. Unilateral vaginal extirpation of a pyosalpinx, with preservation of the uterus and the opposite appendage, is only practiced when the opposite side is known to be healthy, and when the pus has lost its virulence, as in 3.
7. The vaginal incision is not practiced as a method of treatment except under special indications. The permanent results do not as yet show that it merits a leading place as a method of treatment.—*Archiv. für Gynäkologie*, Bd. 64, H. 1, 1901.

George R. Southwick, M.D.

THE TREATMENT OF ABORTION.—(Reed.)—The use of ergot to hasten the abortion is generally advised, but it is to be unhesitatingly condemned. The tetanic contractions induced by ergot are not favorable for the satisfactory emptying of the uterine cavity. The tampon is safe and more efficient. It stimulates uterine contraction, dilates the os and stops hæmorrhage, both

mechanically and dynamically, besides maintaining a condition of surgical cleanliness. The principal contra-indication to the use of the tampon is the presence of sepsis. The tampon should not be employed after the sixth month except to pack the uterus. Wash thoroughly the external genitals and vagina with green soap and hot water, followed by a lysol douche, 2 per cent. Prepare the hands and instruments as for laparotomy. Depress the perineum with a Sims' speculum and pack the sterile gauze first around the cervix and then fill the vagina with it. The time for the douche is before and after curettement, to cleanse the canal and wash out any loose detritus from the uterus and vagina, and to provide for the elimination of germs introduced from without at the time of the operation; but here its function ends. It is unnecessary, useless and injurious, both in normal labor and abortion, as the experiments of Krönig and others have shown.

In cases of abortion where sepsis is already present, as shown by the elevation of the temperature and pulse, or of the pulse alone, active interference is definitely and urgently indicated. The uterus should be curetted at once and the cavity thoroughly washed out with a hot 1 per cent. lysol solution.

Every abortion must be regarded as a severe surgical case, and treated as such.—*American Jour. of Obstetrics*, August, 1901.

George R. Southwick, M.D.

THIOSINAMINE (MERCK) IN THE TREATMENT OF CANCER OF THE UTERUS.—(Dudley.)—Dr. Dudley reported before the American Gynæcological Society remarkable results, with this remedy, in the treatment of an advanced cancer of the cervix and body of the uterus. It was injected hypodermatically into the vaginal vault and into the outside thigh. It produced no constitutional effect other than a stimulation of the nervous system, such as would be brought about by strychnia. He used it because it was recommended as a great absorber of scar tissue. He had used it in two cases of septic infection of the arm and hand, with splendid results in clearing up the scar tissue as the result of various cuts. He used it (thiosinamine, prepared by Merck in 15 per cent. solution) in doses of ten to thirteen minims, injected hypodermatically twice a week.—*American Jour. Obstetrics*, Aug., 1901.

George R. Southwick, M.D.

ALUM ENEMA AFTER ABDOMINAL OPERATIONS.—(Hardon.)—The writer has found it especially valuable in exciting peristaltic action of the bowels in abdominal distention after operations, and that it succeeded after enemas of soap and water, castor oil, glycerine, turpentine and oxgall were successively used, but without avail. He uses one ounce of powdered alum in a quart of water for an enema. He has had uniform success with it for nine years.—*American Jour. Obstetrics*, June, 1901.

George R. Southwick, M.D.

GELATIN IN CONTROLLING HÆMORRHAGE.—In the non-operative treatment of internal hæmorrhage there is a dearth of reliable remedies. After discussing the uses of ergot and morphia, Sailer mentions some experiments on animals of the intravenous injection of gelatin, and observes that the blood coagulability was thereby increased. It was also found that gelatin injected subcutaneously acted in the same manner. Although gelatin has been used as a local application for wounds to control hæmorrhage, its internal use has only recently been suggested. The first case in which it was

used was one of gastric ulcer, and since that time it has been used to control bleeding from the bladder and bowel in cases requiring interference. Particularly is its use to be advised in the treatment of hæmorrhage from the bowel in cases of typhoid ulceration.

Technique of Employment.—The gelatin is prepared as for ordinary media, using a .5 to .8 per cent. saline solution instead of bouillon. Thus, to make a litre of 10 per cent. gelatin, 5 gms. of salt, a litre of distilled water, and 100 gms. of gelatin are taken. The water is brought to 80° C., and the gelatin slowly stirred into it until it is dissolved. It is important to avoid boiling at this stage. The mixture is then removed, cooled to 40°, and the white of one egg thoroughly mixed in it, and stirred for several minutes. The mixture is again placed on the stove and brought to boiling, causing the coagulation of the white of the egg and a partial clearing of the solution. It is then filtered through gauze and paper. The amount of pain experienced in its use is in proportion to the turbidity of the solution. It is put away in flasks or test-tubes, and sterilized for fifteen minutes on three successive days. When ready for use they should be heated to 38° C. The best way is to have ready a cup of hot water, into which the tubes may be placed.

The liquefied gelatin is poured into a glass, drawn into a syringe and injected. The dose recommended is 10 c.c. of a 10 per cent. solution as often as required to control the symptoms. The usual situations for injections are under the breast, between the shoulders, and on the outer side of the thigh.

For administration by the mouth, 100 c.c. of a 10 per cent. solution may be employed every two hours.

The conclusions reached from the investigations are: (a) gelatin increases blood coagulability; (b) taken internally or hypodermatically it is harmless; (c) it appears to be the best remedy for hæmophilia and hæmorrhagic forms of the infectious diseases; (d) it is contra-indicated in acute nephritis.—*Therapeutic Gazette*, August 15, 1901.

William F. Baker, A.M., M.D.

OBSERVATIONS ON TYPHOID FEVER COMPLICATED WITH CROUPOUS PNEUMONIA.—Fisher remarks that the above complication is not unusual, but, because of the absence of pain, chill and rise of temperature, so suggestive of pneumonia, it is apt to be overlooked. It seems probable that such cases are due to a mixed infection. In fatal cases both the typhoid bacillus and the pneumococcus have been found in the lungs. Observations seem to show that the complication has been more frequent since the introduction of the cold-bath treatment, and also that the mortality of the same since this treatment has been instituted has been considerably less.

As to the diagnosis, it can be said of this complication that if, in the course of the second or third week of typhoid, there is a marked leucocytosis, it ought to be suspected. Dostaix observes that the normal leucocytosis of the first week of typhoid diminishes rapidly in uncomplicated cases after the seventh day of the disease.—*American Journal of Medical Sciences*, August, 1901.

William F. Baker, A.M., M.D.

PSEUDO-MEMBRANOUS INFLAMMATION OF THE MUCOUS MEMBRANES CAUSED BY THE PNEUMOCOCCUS.—(Carey and Lyon.)—The summary of the case is as follows: Acute lobar pneumonia of both bases, with the devel-

opment during the first ten days of a profuse pseudo-membranous exudate, first on the tonsils, and quickly extending to the mucous membrane of the lips, tongue, mouth, palate, throat, and transferred to the eyes, glans penis and anus; signs of fibrinous pleuritis; persistent tympanites; membranous shreds in the stools; absence of the diphtheria bacillus, streptococcus, saccharomyces albicans, and the presence in abundance of the pneumococci. The pneumococci were grown in culture, injected into rabbits, and recovered from the blood of those animals.

The membranous exudate on the lips was a thick, white, gelatinous material, partly soluble in water. It appeared the same on all mucous surfaces, and contained pneumococci.

The case is interesting on account of the extent of the infection, for the whole gastro-intestinal tract was involved. This is shown by the appearance of the stools and the tympanites. The infection seemed to have been carried from one place to another by the boy's fingers.—*American Journal of Medical Sciences*, September, 1901.

William F. Baker, A.M., M.D.

LATENT MICROBIC-ENDOMETRITIS IN PREGNANCY AND PUERPERAL FEVER AND ITS PROPHYLAXIS.—(Albert.)—The studies of the writer as senior physician to the Dresden Women's Clinic lead him to believe there is great need of further explanation of the etiology of puerperal fever. In 1898, one-fourth of the women suffering from a rise of temperature, out of about 2300 deliveries, were known to have had gonorrhœa. This infection must have taken place before pregnancy. There are other microbes besides the gonococcus which may be found in the endometrium of a pregnant woman and which may remain dormant during pregnancy, and under the changed conditions of labor and the puerperium develop their virulency and cause puerperal diseases of the most severe type. In 6500 births, in the last three years, there were eighteen such cases with six deaths which could not be explained in any other way. The writer does not agree with Menge and Krönig, that the uterine cavity is free from bacteria. He refers to the investigations of Winter and Walthard, who found bacteria in from 26 per cent. to 82 per cent. of the cases examined. The latter found that indifferent streptococci of the genital tract could be developed to full virulence. This latter condition was found in 78 out of 190 healthy puerpera examined. These results also agree with clinical experience. The writer is of the opinion that many of the pathological complications of pregnancy, labor and the puerperium, even hyperemesis gravidi and eclampsia, are to be explained by microbic infection of the endometrium. Most of the diseases of the endometrium are of infectious origin. Cases of pelvic cellulitis developing after a curettement, in spite of the most careful asepsis, are due to latent organisms in the uterine cavity. Not every woman who aborts with a high fever and dies from sepsis should be accused of criminal abortion. The vagina may afford lodgment to any pathogenic organisms which later reach the uterine cavity, especially during menstruation. Germs find their way in the dust of the street or the room, and should be guarded against by wearing closed drawers. All cases of leucorrhœa, or any disease which may convey bacteria to the genitals, should be treated carefully. The prophylaxis of puerperal fever means more than asepsis at the time of labor.—*Archiv für Gynäkologie*, Bd. lxxiii., Hft. 3.

George R. Southwick, M.D.

THE SUCCESSFUL TREATMENT OF A TUBERCULAR ULCER OF THE BLADDER.—(Roerig).—The ulcer was situated between the urethra and the right ureter (tuberculous cystitis). The bladder was very sensitive and held sixty c.cm. The subjective symptoms were severe. Various therapeutic measures were tried unsuccessfully, such as instillations of guaiacol-iodoform emulsion, later 1 : 5000 corrosive sublimate, and stronger, with cleansing of the ulcer. Tuberculocidin, Klebs (Tet.), was then used, at first five drops, which was increased gradually to forty drops a day. Once in two or three weeks the instillations of sublimate were repeated. The tuberculocidin was also used locally by injecting five grams of the tincture into the bladder just after emptying it. The results of three months of this treatment were remarkably good. The patient was able to work, free from pain, slept normally, had no tenesmus and a bladder capacity of 3509.—*Centralblatt für Gynäkologie*, No. 34, 1901.

George R. Southwick, M.D.

THE CONSERVATIVE TREATMENT OF INFLAMMATORY TUMORS OF THE APPENDAGES (SALPINGITIS).—(Thompson).—The recent satisfactory reports of conservative treatment of salpingitis, even in operative cases, are noteworthy. The writer's experience was mostly with chronic cases of a severe type which had been treated unsuccessfully before applying to him. The results were satisfactory in the great majority of the cases by the use of rest, vaginal douches, sitz baths, hot-air baths, vaginal tampons, compresses and massage. Intra-uterine treatment, such as dilatation, curettement or cauterization, was never used except under strict indications, such as uterine hæmorrhage and leucorrhœa. Grammatikati's method of systematic intra-uterine cauterization, which has been extensively used in Russia, was not tried, as the writer has seen harm follow and the nervous system suffer severely from so much manipulation. When the methods of treatment mentioned failed and the persistence of the inflammatory tumor meant the presence of pus, the writer opened the pus cavity by a free vaginal incision in the median line to avoid the ureters and uterine arteries. The pus pockets were opened under the guidance of the finger inside, aided by the external hand. The peritoneal cavity is usually shut off by adhesions. The principles of treatment were free incision, drainage, and thorough irrigation of the pus cavity with peroxide of hydrogen.

The writer made the vaginal incision in thirty cases. Seven were simple pyosalpinx, twelve were pyosactosalpinx (pyo-ovarium), complicated with peritoneal and pelvic cellulitis exudates, in five cases the origin of the pus could not be determined exactly, in six cases the pus sac had broken through into the rectum and recovery was not prevented in consequence, two cases were complicated by uterine fibroids. All the cases made good recoveries excepting two, which died some weeks later from suppuration and debility. One of these cases was complicated by a large fibroid which could not be removed on account of the debilitated condition of the patient; the other case was a large pyosactosalpinx and pelveoperitoneal abscess, which were opened by laparotomy, and afterwards by vaginal incision, with only temporary benefit. The ureter was injured in one case. The writer has used the vaginal incision in eight cases of large pyosalpinx tumors extending to the navel with satisfactory results, and urges this method in preference to extirpation.—*Centralblatt für Gynäkologie*, No. 20, 1901.

George R. Southwick, M.D.

THE TREATMENT OF PRURITUS VULVÆ.—(Siebourg.)—The writer noticed that the sensibility of the skin was much diminished after subcutaneous injection of a considerable quantity of physiological salt solution, and has tried it with success in cases of chronic pruritus vulva after other methods have failed. He recommends in general the following treatment for this condition. He emphasizes the importance of careful search for the cause in local disease and urinary analysis. A simple diet must be observed. Exercise to promote sleep, late to bed and early to rise, and short finger-nails, are necessary.

The genitals must be bathed for five minutes with soap and cold water, night and morning, and after each micturition. Solutions of carbolic acid are excellent for this purpose. The following ointment is prescribed, especially when there are adhesions to the skin: Cocain 2.0, orthoform 1.5, menthol 0.5, acid carbol. 1.0: 20.0 vaselin. The patient should keep this ointment always at hand and apply it to the itching spot instead of scratching it. Fissures in the skin or mucous membrane should be painted with a 10 per cent. solution of sulphate of copper to heal them quickly. A piece of gauze on which the ointment is smeared is laid over the itching surface at night and covered by a large compress of cotton pressed firmly against the parts by a T bandage.

In chronic cases, when the skin and mucous membrane are intact, the writer recommends the following mixture: Spir. rusci 50.0, acid. salicyl. 0.5, resorcin 1.0, which is to be applied with a pencil night and morning after washing. It is where the above measures fail that the subcutaneous use of a considerable amount of physiological salt solution is recommended, enough to raise the skin and stretch the nerves.—*Centralblatt für Gynäkologie*, No. 26, 1901.

George R. Southwick M.D.

THE VALUE OF VERATRUM VIRIDE IN PUERPERAL ECLAMPSIA.—A summary of the replies received to letters addressed to the most prominent obstetricians in the United States by Eggar, of Cornell, shows that since the pathology of eclampsia is unknown, the treatment must be empirical, and from a clinical standpoint alone. The action of veratrum viride in that condition is as a depressant to the pulse-rate. It reduces the number of convulsions, for, as the pulse is lowered to 60 or below, the convulsions become very infrequent. It reduces the temperature, relaxes the cervix, causes a prompt diaphoresis and diuresis. The dose is 10 to 20 m. of fluid extract, or one-half that quantity of Norwood's tincture, repeated every 20 to 30 minutes until the pulse falls below or to 60 per minute. Norris, of Philadelphia, states that the judicious use of veratrum has quieted the circulation, the nervous symptoms disappearing and convulsions are warded off. The class of cases requiring its use is that in which is found a full, bounding pulse and patient returning to consciousness between the convulsions. Where the pulse is rapid and weak, no results are to be seen. Dose, 8 minims (measured by the indicator of the syringe) of the fluid extract, and repeated in 5-minim doses as soon as the effect of the former dose wears off. Hirst, Philadelphia, gives as the indications for veratrum viride strong, bounding pulse, face suffused, and the type of cases known as sthenic. In asthenic cases he would not employ it. The action is to reduce the pulse-rate; and as the pulse-rate is lowered the frequency of the convulsions is diminished. Boyd and Wilson, of Philadelphia, speak unfavorably of the drug. Wilson states that he places no dependence upon it. Others replying state that they have had no experience with the drug.—*Therapeutic Gazette*, August 15, 1901.

William F. Baker, A.M., M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

A PERMISSIBLE AND UNOBJECTIONABLE ADJUVANT IN THE TREATMENT OF ACUTE PARENCHYMATOUS NEPHRITIS.—Dr. F. W. Wood, of Cook County Hospital, Chicago, has taken the trouble to report in detail the histories of several cases of acute parenchymatous nephritis that were treated in that institution under his supervision. These records convince, beyond peradventure, that *high colonic flushings, followed by the introduction of varying amounts of a normal salt solution*, are almost uniformly followed by beneficial results in the disease under consideration. These beneficial effects are manifested not alone in the renal organs, but upon the whole system. Edema of the extremities rapidly disappears, headache and backache cease to annoy, the mind clears, the appetite is stimulated, and, best of all, the whole intestinal tract becomes active, so that toxic elements, which are said to play so important a rôle among the etiological factors of nephritis, are quickly and efficiently eliminated. This is accomplished, too, without the use of active cathartics, which are certainly open to some objections. The cases reported by Dr. Wood also show that we may expect to obtain from this simple adjuvant treatment marked diuretic effects. The amount of urine passed in some of his cases reached 156 ounces during the twenty-four hours. It does not seem to matter whether the acute nephritis is a complication of one of the infectious diseases or not; in either class of cases colonic flushings are useful. We are happy to be able to say that we have, a number of times, witnessed just such prompt and beneficial effects as Dr. Wood has described, and we feel that the plan of treatment he advocates is deserving of all praise. The patient should be put to bed after a warm bath and protected from draughts; should be given milk, or at least a liquid diet; should be requested or even forced to drink an abundance of pure water; should receive every four hours the high colonic flushings, followed by a pint or less of the normal saline solution, which latter should be retained; and last, and most important of all, should receive, medicinally, nothing save the homœopathic remedy indicated by the more prominent, peculiar and characteristic symptoms of the case. Doubtless the remedy will often be Belladonna or Cantharis, as shown in Dr. Wood's cases. If the remedy in these cases is chosen carefully and sensibly, it will act more quickly and more satisfactorily if given in potency. Acute nephritis complicating scarlatina or the other infectious diseases sometimes requires the hot pack in addition to the treatment outlined above.—*The Clinique*.

O. S. Haines, M.D.

REMARKABLE CURE OF FACIAL NEURALGIA.—Dr. Chakravati mentions the case of Mr. M., aged 35 years, who had been suffering from severe neu-

ralgia of face and sub-maxillary nerves of both sides for months, in spite of the treatment of many allopaths and some homœopaths. Bell., Cham., Cedron, China, Kali bich., Glon., etc., had failed to relieve him. *Guaphyllum* 30th, one dose each day, cured him within three weeks. The symptoms of this case were as follows: Tearing, lancinating and pulsating pains, worse in the evening, after eating, in the fresh and cold air, and from the least mental exertion. The pains were so severe and so unbearable that he would cry and throw himself about. The color of the face was livid, with cold perspiration. Excessive hyperæsthesia was present, and a slight touch would greatly provoke the pains. (Now, if Dr. Chakravati had only told us something about this remedy, *Guaphyllum*, we would have been glad.)

O. S. Haines, M.D.

NEW METHODS IN THE TREATMENT OF THE INSANE.—That distinguished alienist, Dr. Selden H. Talcott, of whom the entire homœopathic profession is justifiably proud, has contributed an interesting paper upon the above topic to the *North American Journal of Homœopathy* for September. He says probably no class of sick people has ever been more thoroughly misunderstood or more cruelly maltreated than the insane. For thousands of years the insane were treated with marked and positive brutality simply because those who took care of them did not know the nature of the malady. Now that it is a recognized fact that insanity is a departure from the normal mental status, and that this departure is due to some diseased condition of the brain or nervous system, the insane are beginning to receive hospital care for the purpose of effecting their restoration to health if possible. The new and scientific "hospital idea" comprises the administration of *thoroughly proved* and *carefully selected* remedies for the cure of disease by skilled and experienced alienists. It also affords rest treatment for those who need it. Such patients require, too, the general care of trained nurses, and the question of diet naturally excites much attention. A *hot liquid diet* affords the best possible means for physical recuperation, and the restoration of the physical health is the first step recognized now as a necessity in the cure of insanity. *Hot milk* is the leading hypnotic at the Middletown Hospital. If a patient refuses nourishment, then he or she must be fed by means of a tube passed through the nose and thence into the stomach. After the benefits of the treatment described have been secured as far as possible, then come naturally exercise, occupation and amusement. It is to be hoped that every member of our school will own a copy of Dr. Talcott's latest book upon "Mental Diseases and Their Modern Treatment," because it teaches how to apply the advanced means for the care of the insane, in accordance with what is now known as the "hospital idea;" and this is what every one should know in these progressive modern times.

O. S. Haines, M.D.

THE CHARACTERISTICS OF THE CONSTIPATION CURABLE BY SILICEA.—While it must be seldom that we shall feel called upon to prescribe for a constipation primarily, yet frequently the constipation is at the bottom of a whole train of symptoms complained of, as well as the prime cause of the particular complaint for which relief is sought. This forms the introduction to a chatty little article by J. W. Hingston, M.D., in the *Advocate* of July 15th. The constipation for which Silicea will be found to be the similimum is *obstinate, from inactivity of the rectum*.

This inactivity is not a perfect torpor as it is in the *Opium* case; where there is *no* desire for stool, and the lower bowel seems absolutely without feeling. In *Opium*, the whole bowel is to all appearances dead, without peristalsis. Not so in the *Silicea* case. Here there is a *normal desire*, but effort is unsuccessful, because of an apparent lack of power of the rectum to expel a rather large and hard stool. We have a similar normal desire in *Alumina* and in *Platina*, but in these latter remedies the stool is neither hard nor large. It is, on the contrary, pasty and sticky like clay, and it often adheres annoyingly to the anus. Again, this condition of inactivity of the rectum in *Silicea* cases is accompanied, not infrequently, with a *contracted anus*. In this respect it resembles *Lycopodium* and *Plumbum met.* In *Silicea*, the stool is partially expelled, and then, the force giving out, it slips back. As a result of this contraction, we have painfulness of hemorrhoids, which may become incarcerated. Thus, also, we have fissures produced, because the adjacent surfaces break instead of stretching on the large stools. In the case of *Nitric acid*, for example, fissures are produced by constant maceration and erosion of the tissues in the moisture which is almost always present around the anus.

The desire for stool is *normal* in *Silicea*. In this respect it differs from *Nux vom.*, which has *much desire*, principally *abdominal*, and *Sulphur*, which also has much *urging* and *pressure*, principally in the *rectum*. Occasionally, in the *Silicea* case, the abdomen is sensitive to the pressure of the clothing, like *Lachesis*, but there is again lacking the distention of the abdomen and the rumbling and incarceration of the flatus which is so common in cases requiring *Lycopodium*. In the uninterrupted constipation of infants with "sweaty heads," *Silicea* will be oftener of service than either *Mercurius* or *Calcarea carb.* On the other hand diarrhœa, alternating with the attacks of constipation, would be apt to be the case in the *Merc.* and *Calc.* cases.

Occasionally, in young people just merging from their teens, a constipation, an irritable sphincter and a cough will bring on the sallow cheek, the hectic flush, the thin visage and the stooped form, which will lead us to suspect consumption. The tired body, the indolent mind and the melancholy mood of such subjects intensify the picture. This is not consumption. It is the ground or soil upon which the seed of that disease will take root, however. *Silicea* may prevent such a catastrophe, and here it vies with *Tuberculinum* and *Sulphur* for first place. (The good homœopath will add such characteristics of the *disease* as these to the characteristics of the *patient*, and thus he will prepare a perfect totality upon which he may successfully prescribe his curative remedy.)

O. S. Haines, M.D.

EXCLUSIVE SOUP DIET IN TYPHOID FEVER.—Dr. A. Seibert, of New York, has written entertainingly of typhoid fever in the July number of that excellent journal, *The Medical Era*. During the course of these remarks, he called our attention to the doleful state of our treatment of the gastroenteritis of childhood, previous to the recognition by the profession of the imperative therapeutic necessity of withholding all milk from such cases until cured. Evidently, to Dr. Seibert's mind, these patients who are to-day fed on milk during an attack of typhoid fever are but little better off than our former little patients were during their attacks of summer-complaints. The conditions are, however, not identical in the cases compared by the author. Typhoid fever is not gastroenteritis, nor are the majority of our cases of typhoid

fever in children. Yet the subject is one for careful and thoughtful consideration. Dr. Seibert's results, under his plan of treatment, have been, unquestionably, excellent. During the initial twenty-four or forty-eight hours he allows only plain cold water. Then soups are given. Soups made of meat broths, containing rice and peas, lentils, and later the yolk of egg. Oatmeal and barley may also be added. Of course, such a soup must be carefully strained; then it is allowed in quantities of one-half to one pint every three hours. Smaller quantities are given to children. During the night nothing but water is allowed. Five meals in all are given during the day. This method of feeding typhoid, who would not or could not take milk, upon vegetable broths, has been often referred to by Dr. August Korndorfer, Sr. We have relied upon it, not universally, but in selected cases, and have nothing but praise for it. Dr. Seibert, however, does not treat his typhoid patients homœopathically. He allows them dilute hydrochloric acid in doses of five to fifteen drops before each meal, irrespective of the height of the temperature or the frequency of the stools. How one could dispense with the assistance of the *homœopathic remedy*, in his treatment of typhoid fever, we cannot understand. Dr. Seibert also thinks well of gentle colon washings, two or four times daily.

O. S. Haines, M.D.

"COUGH WITH ERUCTATIONS."—This symptom, although rather unique, is not infrequently a prominent and peculiar one in the patient's totality. It may be found in the pathogenesis of a number of remedies, but Dr. C. M. Boger says that in his experience *Kali. bich.* and *Sanguinaria* are the common ones with which he has cured. The symptom is likely to be present in the gastric affections of excessive beer drinkers. This would again suggest the *Kali. bich.* for study.—*Medical Advance.*

O. S. Haines, M.D.

THE ACTION OF THEA UPON THE HEART—TACHYCARDIA.—It is a well-known fact that the popular beverage "tea" has a decided action upon the circulation and upon the heart. Dr. T. C. Duncan, of Chicago, relates the case of a laundry girl who was an inordinate user of tea, and who suffered from severe attacks of tachycardia, followed by faintness, and this, again, by headache.

The heart in this case was decidedly hypertrophied, and finally, after one of the attacks of tachycardia, there developed a partial paralysis of the face and ptosis. It would seem, therefore, to be a good plan for physicians to inquire regarding the tea habit in cases suffering from "heart attacks" followed by faintness, etc. *Theine*, the alkaloid of tea, produces well-marked effects upon the brain and stomach through the circulation; hence the large number of precordial symptoms. These latter are especially worthy of careful study. "Anxiety in the precordia, sometimes described as a feeling of anxious oppression." "Oppression, with a sense of anguish in the region of the heart." "Acute pain, as from a spasm, in the region of the heart, and in spite of all his efforts he felt as if he was about to faint." The direct action of tea upon the heart is shown by the following symptoms: "Palpitation at night, with inability to lie upon the left side." "Heart palpitates, and, again, feels as if quite motionless." "Fluttering of the heart, succeeded by momentary suspension of its action, and long-continued swoonings." The irregularity of the circulation, under the influence of this drug, is well seen in the pulse records:

"Pulse very *rapid*, irregular and often intermittent. Pulse quick, small and feeble. *Hurried* pulse. *Fast* pulse. Pulse at first *accelerated*, afterwards diminished, irregular and intermittent. Pulse scarcely discernible and extremely irregular." In such cases as have abused tea, the author has found dilatation with thinning of walls. The remedy that acts as a valuable antidote to the poisonous effects of tea is *Pulsatilla*. It is a dynamic antidote. Much of the precordial distress suffered by inveterate tea-drinkers may be from the dilatation of the stomach, so often met with in this class. This, also, is well met by the *Pulsatilla*.—*Clinical Reporter*, September. (It would be well for us to study the pathogenesis of Thea in its relations to that most troublesome of affections, tachycardia.)

O. S. Haines, M.D.

ABIES NIGRA: A POSSIBLE REMEDY FOR SOME CASES OF BRADYCARDIA.—Dr. T. C. Duncan, in the *Homœopathic Recorder* for September, has a short article upon this useful remedy. It appears probable that it may be useful in the treatment of some cases of bradycardia. True, it is not, primarily, a heart remedy; but it has produced some very suggestive symptoms, and should not be overlooked in such cases where the symptoms correspond. Dr. J. B. Bell has taken the remedy in various potencies, from the tincture, indeed, to the 30th; and has invariably confirmed the earlier provings, in that he has produced upon himself such symptoms as: "Heavy, slow beating of the heart, followed by dyspnœa, and after awhile sharp pain in the heart." It seemed to him as if the cardialgia was finally produced by the strong, slow contraction. We are more familiar with the *Abies* stomach symptoms: "A sensation as if a lump or hard-boiled egg lay in the stomach." It is possible that the case of bradycardia in which *Abies* will prove to be curative will have this stomach characteristic as well as the heart symptoms. (The *Abies* patient is gloomy and melancholy; he suffers from a sense of constriction just above the pit of the stomach after he has eaten; he belches and often vomits; his stomach distress and pain, as from a hard-boiled egg, may extend to the left side.)

O. S. Haines, M.D.

EXTRACTS FROM THE MINUTES OF THE BERLIN SOCIETY OF HOMŒOPATHIC PHYSICIANS.—Dr. Windelband recited his experience with *Chininum ars.* in the after effects of influenza, claiming excellent results from its use.

Dr. Bree used *Camphor* (Rubini's tincture) in several cases of influenza, employing it throughout, and claims to have shortened and greatly ameliorated the course. In the anginas of influenza characterized by swelling and redness he has obtained better results from *Merc. cyanatus* than from *Apis* and *Beladonna*.

Influenza.—Dr. Gisevius laid stress upon the importance of finding the remedy that best suits the epidemic when influenza is prevalent (*genus epidemicus*). *Bryonia* is especially valuable when there is headache, the pain going from front to back of head; also intestinal derangements and sour sweat. *Merc. sol.* also has sour sweats. In severe lung affections with decided loss of strength *Tartar emetic* and *Phosphorus* are most important; next come *Ammon. carb.* and *China*. He has also had good results from *Chin. ars.*, especially in neuralgia following influenza, when the pains are relieved at night by sitting up. *Camphor* and *Eucalypt. glob.* have also given him results. Pleurisy he treats with *Sulphur* in alternation with either *Canth.* or *Apis*. *Rhus rad.* is important in pleuritic pains.

Inflammation of the antrum of Highmore calls for *Merc. sol.*, *Hepar, Silicea*. Locally a 10 per cent. salve of *Sanguinaria* is useful; should be applied as tampons.

Kali carbonicum.—This remedy was discussed by several members at the meeting held March 14, 1901. Dr. Windelband said: *Kali carb.* is especially indicated in cardiac weakness, cardiac dropsy; long-delayed menses at period of puberty. Useful in pertussis with tickling cough at night, especially in those of the phthisical habitus. Hahnemann recommended it in pleurisy with purulent exudation. He has had good results from it in hip-joint disease.

Dammholz obtained good results from it in stitching chest pains in tuberculous subjects. Another strong indication for *Kali carb.* is backache during pregnancy or after abortion.

Gisevius remarked that *Kali carb.* was a wonderful remedy in hip-joint disease, especially when pronounced sweating is present.

Kali bichromicum.—Gastric catarrh with heavily-coated tongue; diphtheria; ecthyma syphilitica; leucorrhœa; sciatica, worse from stooping and motion, better from pressure and rest.

Kali bromatum.—Dr. Windelband employs this remedy in small doses for teething children to control the nervous erethism.

Caladium seguinum an excellent remedy in pruritus vulvæ.

Kali hydrocyan. hypodermatically in the third and fourth dilution in cholera Asiatica (Windelband).

Hepar sulph.—Dr. Gisevius finds *Hepar* curative in croup and in fibrinous bronchitis. He mentions two cases of the latter disease that were speedily cured.

Kali picronitr. gave good results in recent cases of prostatic hypertrophy. Also in icterus with swelling of the liver; old malarias with hepatic derangement. The characteristic symptom is itching of the skin.

C. Sigmund Raue, M.D.

CURES WITH SILICEA AND PHOSPHORUS.—A certain Dr. L., practicing in Australia, reports the following cases in the *Homœopathische Monatsblätter*, Sept., 1901.

Caries of the Femur.—A child 9 years old was afflicted since 1½ years with caries of the femur. In the course of the illness several splinters of bone had been already thrown off. Three allopathic physicians had decided that an operation would be necessary, as a result of which ultimatum the parents decided to try homœopathy. Dr. L. prescribed *Silicea* 6th trituration, three times daily, and ordered the limb to be enwrapped in a warm, moist dressing. Under this simple form of treatment a complete cure resulted in four months.

Double Pneumonia.—A baker, æt. 36 years, was attacked with this severe disease and had been given up by his old-school attendant. Dr. L. was sent for and found the patient in a critical state; unconscious, with frothy saliva oozing from the mouth, and a reddish-brown expectoration. He ordered a lukewarm sponge-bath, to be followed by a similar pack. *Phosphorus* 4th dilution was administered. The patient promptly showed signs of improvement, and phosphorus was continued. He made an uneventful recovery.

A. Sigmund Raue, M.D.

THE ACTION OF THE VANADIUM-SALTS UPON THE LIVER.—Dr. G. Siefert in *Allgemeine Hom. Zeitung*, Sept., 1901, reviews the provings of *Ammonium-vanadium* made upon animals by John Priestley, which conclusively demonstrate that this substance is capable of rapidly producing a fatty degeneration of the liver. Naturally a pathogenesis obtained by Hahnemann's method would be most desirable, but this is not feasible owing to the great toxicity of vanadium-acid, and on the other hand we can infer the similarity of action in man and mammals. However that may be, we possess on the grounds of the Law of Similars a remedy for this [fatty] degeneration. And without belittling Dr. Berthail's achievements, we can say that the favorable results he has obtained in tuberculosis, anæmia, chlorosis, neurasthenia and leucocythæmia owe a debt to the great principle of Hahnemann.

C. Sigmund Raue, M.D.

ON THE SUGGESTIVE VALUE OF THE UNCOMMON OR PECULIAR FEATURES OF THE CASE.—Dr. Edward S. Haines, of Rutledge, relates an interesting experience, in which a single peculiarity of the case served to *direct attention* to the curative remedy, subsequent study confirming its complete similarity to the totality, and the results of its administration proving the validity of our law. "Baby W. F., aged three months, was an apparently healthy child at birth. Very soon its nurse complained to the physician that the bowel movements were loose and of unusual color. Examination showed that the infant had about ten or twelve daily evacuations, of a *greenish* color and slimy. Next, food began to disagree. He *vomited* frequently. Among the foods tried might be mentioned six well-known and highly-esteemed preparations. At last, peptogenic milk powder seemed to do better. The vomiting ceased, but the stools were just as bad, and baby steadily 'went down hill' until he was skin and bones and looked like a diminutive old man. An allopathic physician had kept him upon paregoric for some time without benefit. The above conditions had really existed then, almost without interruption, for *three months*. Finally the baby had a convulsion, and parents thought the end had come. Dr. Haines had prescribed a number of remedies without success. During a systematic review and study of the case, it was observed that while the numerous stools were green when passed, if allowed to stand a short time they changed to a *bluish* tint, light bluish. This was regarded as unusual and peculiar, and a search of the repertories for such a symptom was begun. At last, in the Repertory to the Guiding Symptoms of Hering, was found the symptom under green stools. '*Green stools, changing to a blue, slate color on standing.*' This was a 'more than once' confirmed symptom of *Veratrum album*. *Veratrum album* was administered in the 30th dilution." This report of the mother of the child is *verbatim*. "We thought he was dying; we kept on giving the medicine, in drops, all night; towards morning we thought he was a trifle better; next day he only had five movements, and they were bright yellow instead of blue." From this point onward, convalescence was steadily maintained. The child is at present slightly constipated, but is bright and looks like any three months' old baby, save that he is thinner than normal. He hardly ever cries now. Some of the characteristic symptoms of *veratrum* were not present in this case, such as the cold clammy sweat, etc., but the one striking peculiarity of the case called for the remedy, and the general picture was one not unusual after prolonged *veratrum* diarrhœas. We might add that the child was so low when the *veratrum* was given that

the physician did not return to the case next day, feeling that a report of death would reach him. The Law of Similia affords the only solution for such problems as this one.

O. S. Haines, M.D.

THE "SATURATED" SOLUTIONS OF POTASSIUM IODIDE.—Some time since Mr. E. Parratt called our attention to the uncertainty of the dosage of the iodide when administered in the form of the so-called saturated solution. He was very doubtful whether the usually accepted belief that one drop represented one grain of the salt would hold good save in those solutions that were very accurately prepared. Dr. Schroeder, of Cincinnati, calls attention to the fact that 420 minims of the saturated solution contain but 372 grains of the salt. If dropped from an ordinary prescription bottle, each drop will represent less than *one-half* grain. And it is, moreover, stated as a matter of fact, that the "saturated solution" of many druggists falls short of even this strength, and thus the discrepancy is increased. It is therefore suggested that the drug is one that should be given dissolved, in known quantity, in some bland syrup. The principal reason for the preference of the plain saturated solution has probably been, that it agrees with the stomach better in such a form, well diluted, than when administered in other solutions; but those who count large doses of the iodide among their most precious therapeutic possessions should at least see to it that the strength of their solutions is uniform.

O. S. Haines, M.D.

TREATMENT OF LA GRIPPE—WARNING.—Turning to the report of the German committee which was formed after the epidemic of 1892, and which was based upon the opinions of over 6000 physicians of that country, we find them stating that "patients suffer less from the influenza than from the galenical poisoning." What does that mean? Can you read any other meaning in that report than that the use of toxic drugs did more harm than good? In plain English, killed more patients than it cured. That being the case, the progressive physician, of whatever school of practice, should see to it that whatever he does is along the line of rational therapeutics. That he does not use antipyretics to reduce temperature, which is only one of the symptoms of the disease, and find that he is obliged to make out a certificate showing that "Mr. Blank died of heart disease."—E. Elmer Keeler, M.D., in *Hom. Eye, Ear and Throat Journal*. Most of the antipyretics used are made in Germany, so the German committee ought to know what they are talking about.

O. S. Haines, M.D.

HOMŒOPATHIC AGGRAVATIONS.—Dr. Richard Hughes says that *Colocynth* and *Podophyllin* are the only two medicines from which he has seen homœopathic aggravations. He has become more and more shy of using *Colocynth* in any potency lower than the third, and even there he repeats it very seldom.—*Jour. British Hom. Soc.*

TOBACCO HEART.—Dr. Stonham (*Jour. Brit. Hom. Soc.*) thinks that the aggravation of the crude drug or a low dilution can be antagonized by a very high dilution. Thus, in the treatment of the tobacco heart he gives the patient, first, *Tabacum* 30, and he states that this medicine generally has a marked effect in stopping the symptoms.

O. S. Haines, M.D.

THE HAHNEMANNIAN MONTHLY.

DECEMBER, 1901.

THE CARE OF INOPERABLE CARCINOMA.

BY D. P. MADDUX, CHESTER, PA.

(Presented to the Homœopathic Medical Society of the State of Pennsylvania, Sept. 26, 1901.)

To make even a list of the various "Cancer Cures," (?) or those procedures recommended as "good for cancer," would consume more time than is allotted to this entire section. Such, however, is far from my design. It is my purpose merely to indicate some measures which, in my personal experience, have proven helpful to these most distressing cases, and not in any way attempt to give a *résumé* of measures recommended; believing that if this personal experience is supplemented by the personal experience of others here present, a greater benefit may be obtained.

Furthermore, it is not my purpose to take under consideration, or even to revert to, any of the various operative or remedial measures for the eradication or cure of carcinoma; but rather to consider what we can do to render more comfortable the remaining days of these unfortunates in whom the condition is too far advanced for the successful application of radical measures. I know of no class of cases who appeal more strenuously to us for assistance and sympathy, and none in which our capacity to give the wished-for aid is so limited, and even impotent.

A search through surgical literature shows pages by the hundreds upon pathology, operative technique, curative pastes, in-

jections, etc., etc., but not a line as to the surgical care of those non-operable and past-operable cases of cancer which certainly have the right of appeal for some surgical care; and if these "Fragmeta" seem notably disjointed, it is because I merely present the few points gleaned from personal experience, and have not the benefit of making liberal and learned excerpts from the text-books.

It might be well for our surgical teachers to consider the statement of Dr. Wm. B. Cooly in the "Practitioner," where he states, "However ardent advocates we may be of surgical intervention, to the exclusion of all other methods, in the treatment of cancer, we are nevertheless confronted with the fact that at least 75 per cent. of all cases are, or at least *some time become*, beyond the reach of the surgeon's knife," and to give further aid to the medical student and the profession in the care of these cases, when they have arrived at this lamentable state.

Conversely, Dr. Cooly's estimate should cause every general practitioner to consider to what a degree his own failure in early diagnosis, his own acquiescence to the request of the patient for procrastination, and his own lack of insistency upon an early operation, have contributed to making the "non-operable" so large a class.

We are apt, I fear, to regard a non-operable case of carcinoma as a case beyond help because it is a case beyond cure, and thus lose the mental stimulus of prospective success.

But what can we do? Or what should we attempt to do?

1. We can adopt a surgical dressing that may modify the distress.

2. We can exercise some control over the hæmorrhage.

3. We can lessen the offensiveness of the discharge.

4. We can give the growth good surgical surroundings unfavorable to septic complications.

5. We can successfully relieve much of the distress for a longer period, under the law of "similia," than many of the faint-hearted are aware, and put further off the ever-increasing morphia dose.

6. We can by palliative operative measures, the use of X-rays, electrical cataphoresis, serum or other injections, prolong life, not at the expense of suffering. But of the last clause, as far

as the writer's paper is concerned, it is, as Kipling says, "another story."

The dressing of a case of cancer is, of course, dependent upon its location and stage of advancement; and upon the latter point we must consider the dressing of those cases that are non-operable by reason of the persistent refusal of the patient to submit to operative proceedings, as well as those in which the judgment of the surgeon contra-indicates operative measures.

Cancer of the breast is often rendered the most painful form because it is upon such a pendant part, and the proper support, without undue pressure, by any method that is best adapted to the case, will always contribute a quota of relief. I have frequently accomplished this best by a well-fitting pocket, liberally padded with cotton and supported by bands about the neck, with an additional strap about the back, pinned to the outer edge of the supporting neck-straps.

Before the skin has broken, considerable relief may be obtained by the various dehydrating preparations of kaolin and glycerin. These will much relieve the symptoms resulting from tension and pressure. Even after the central portion has broken down a broad band spread about will, by its water-sucking properties, relieve the blocked-up tissues.

Instead of prescribing the proprietary preparations of antiphlogistin, antithermolín, etc., it is my custom to give the following prescription, which I find satisfactory, if, indeed, it is not the precise formula:

R. Kaolin,	1000
Glycerin,	1000 grms. by weight.
Boracic acid,	100
Oil peppermint,	1
Wintergreen,	1
Eucalyptus,	1

Finely-powdered acetanilid I have found one of the most generally acceptable and palliative dressings in carcinoma of the skin or mucous surfaces, wherever it can be applied; and it can be applied liberally and continuously without causing any cardiac depression. Where cardiac weakness exists and the cancerous surface is extensive, it may be well to combine acetanilid with boric acid, zinc stearate, talcum, zinc oxide, or

some other less active ingredient. If burning is a pronounced symptom, menthol powder may be added to acetanilid, and applied sprinkled over the surface.

I think my observation will be confirmed by all who have had many cases to treat that there is benefit in the relatively frequent changing of the character of the dressings. It may be partly a psychic effect; but the fact remains that it is often wise to make a temporary change before the effect of any dressing has lost its apparent virtue.

In cancer of cervix involving floor of vagina it is my custom to frequently pack the upper vagina with some of the various antiseptic powders, using a different powder at each dressing, permitting the powder to remain from twenty-four (24) to forty-eight (48) hours. In this manner I have used acetanilid, pure or combined, as indicated; boric acid, boracic acid and zinc oxide, tyree antiseptic powder, glutol, zinc stearate, and pulverized charcoal, alone or mixed with any of the above-mentioned powders. Iodoform, alone or in combination, I do not consider with much favor, as it seems to encourage an undue vascularity.

The greasy dressings have not, in my experience, been tolerated for so long a period as the powders; they may, however, prove excellent, in alternation with the powders, in cancer involving skin tissues. I think they are most conveniently and efficiently applied by means of an oil atomizer. In this manner ichthyol, salicylic acid or carbolic acid may be added to castor or olive oil and sprayed upon a surface where itching is one of the most troublesome symptoms, or menthol added to relieve the burning. Menthol in lanolin will often be of benefit.

Chloretone has not been, in my experience, of material benefit as a local anæsthetic. In some cases of intense burning the use of ice-bags or the chloride of ethyl spray is a warrantable temporary expedient.

The advantage of applying the oils by spraying is that patients can more readily make an application themselves; perchance through the night they can a number of times apply it without getting out of bed, thus gaining naps that otherwise would be spent in wakeful pain. It is my custom to explain to the patient the purpose for which the various preparations are intended; and I believe they find a comfort in the fact that some provision has been made for their relief, even though it be but transient in its character.

In the local treatment of hæmorrhage I have run the gamut of all astringents and styptics, and concluded that it was just as well to try the most powerful at first. Hence, I use the powdered persulphate of iron. This I prefer to the Monsel's solution. I apply the powder, or have the patient apply it, by dusting it on parts that are readily accessible, and in case of cervix or rectum, apply it on a piece of gauze or cotton.

Recent experience with the use of adrenaline chloride, adrenaline chloride (Takamine) 1 part, normal sodium chloride solution with 5 per cent. chloretone, 1000 parts, as a local hæmostatic, has proven so satisfactory that I feel glad to join in its recommendation. Where hæmorrhage is protracted, and its results are apparent upon the heart, the saccharated suprarenal glands in one- to three-grain doses per orum, is prompt and efficient.

Dr. W. H. Bates reports upon this drug: "The suprarenal is unique, in that while one-tenth grain has produced the maximum physiologic effect, two ounces caused no further effect;* it has been shown by physiologic experiments that the excess of suprarenal supplied for muscle tissue is stored for further use. It is important also to remember that no results will follow the administration of it unless it is indicated."

The principal caution in its use hypodermically is, that the solution be fresh and aseptic. Dr. Bates recommends the preparation of an aqueous solution by "taking one part of dried powdered suprarenal to ten parts of a saturated solution of boracic acid, and held over a flame until it boils; then it should be filtered, and the filtrate boiled in its permanent receptacle."

I have found no better way of treating the slough of cancer than by treating it with the artificial digestants, and I know of no better one for this purpose than "Enzymol." Mixed with an equal quantity of water and sprayed upon the parts, or applied upon gauze as a wet dressing or pack, it has proven of signal benefit.

As a dressing material where there is much discharge I prefer gauze, and well-picked marine lint or oakum, to cotton. Cotton becomes too soggy and retains the offense longer. As surgical washes, I prefer the use of the solutions of creolin,

* *Journal American Medical Association*, August 11, 1900.

permanganate of potash, bromine water, carbolic acid, methylene blue or formalin, to the bichloride of mercury or hydrogen dioxide.

In cancers involving the tongue or lip, I think saturated boric acid, listerine and glyco-thymoline solutions most applicable. These parts may also be touched up frequently with a solution of methylene blue, 12 grains to the ounce of water.

I will not attempt to give a list of homœopathic remedies. Their indications can be found set forth in more orderly and complete manner in our text-books. I wish to stand on record, however, in the belief that at certain periods, and for certain conditions, they have pre-eminent value. I also wish to enter a most earnest protest against adhering to them too exclusively and tenaciously, at the expense of human suffering. Of course the old rule holds of treating the patient with a cancer, as well as treating the cancer, giving due attention to the condition of the digestion, urinary secretion, bowel action, and matters affecting the general health; but, after all the attention that can be given has been rendered, there will come a time in almost all cancer cases where the suffering is so constant and severe that we are compelled to resort to extreme measures.

I think it should be our study to avoid the use of morphia just as long as we can keep our patient in a reasonable degree of comfort by any other measures, and, when we do commence its use, give sufficient to at least insure a fair degree of sleep.

Among the other drugs we should try before morphia, or perhaps use as alternates or intercurrents with it, are the bromides, chloral, passiflora tincture, and the coal-tar derivatives. Locally, an opium suppository in cancer of cervix or rectum seems to have more effect, with less constitutional disturbances, than when administered by mouth. Cocaine and eucaine, in powder or solution, may be used for a longer period than generally supposed. Chloretone, in my experience, has been entirely unsatisfactory. Lead water and laudanum should not be overlooked as a cooling and sedative solution. There are a number of other methods that have received high endorsement, such as the Roentgen rays, liquid air, the serum therapy, and a number of special injections; but as the scope of this paper is merely personal experiences, I will leave their consideration to those who have made a personal test of their merits.

If I have presented to you nothing of practical value, I feel that the serious lesson to be drawn from the consideration of these saddest of all cases is the duty of all of us to be alive to the earliest possible recognition of cancer, and to the correction and removal of those pre-existing conditions encouraging carcinomatous development; and most strongly does it emphasize the fact that doubtful cases should be judged early by the surgeon.

Cases that should receive a strictly palliative treatment are certainly inoperable, and cases that are inoperable should not be subjected to palliative treatment.

IS THE TREATMENT OF HÆMORRHOIDS BY THE INJECTION METHOD A RATIONAL ONE?

BY T. LOUIS ADAMS, M.D., PHILADELPHIA.

(Read before the Pennsylvania State Homœopathic Medical Society, September, 1901.)

THE title of this paper being in the form of a direct question, I trust the presentation of a few facts, together with an impartial discussion, will place the subject before the profession in a different light from that in which it has been viewed in the past. Without doubt, practitioners generally have formed erroneous ideas regarding this method, regarding its employment in selected cases, and regarding the manner through and by which we obtain satisfactory results; the disrepute into which it has fallen being largely due to the fact that many have attempted its use without first acquainting themselves with the character of cases in which it is applicable.

The object of the paper being mainly to present the writer's idea of the application of this method, it is unnecessary to go deeply into the etiology of hæmorrhoids (which can be readily obtained from any of the standard text-books), further than to state that they are primarily a varicosity of the hæmorrhoidal plexus of veins, no matter what their location, with the exception, however, of the frequently-met-with hypertrophied anal fold.

We will, for the sake of convenience, classify them so as to better enable us to select those cases amenable to this special

treatment. A division, therefore, into two general classes, external and internal, which, in turn, are subjected to several subdivisions, will suffice.

The external varieties, consisting, as they do, of either a ruptured inferior hæmorrhoidal vein, and consequent extravasation of blood into the surrounding tissue, which should be treated by incision and turning out of the clot, and the exaggerated rugæ, or ordinary hypertrophied skin fold, which should be scissored off, will require no further consideration, as under no circumstances would it ever be admissible to use the injection method in this class of cases.

Internal hæmorrhoids are divided into two classes: First, the capillary, formed by the arterial and venous terminals and the capillaries which join them. They are recognized mainly by their predisposition to bleed when disturbed in the slightest degree, are usually quite small, rarely if ever protruding beyond the sphincter unless complicated by growths or other conditions, and require specific treatment other than the one under consideration; and, second, the venous, consisting primarily of a varicosity of the middle and superior hæmorrhoidal veins. This being the most frequent variety, and the particular one in which the injection method is especially adaptable, we will more fully consider it.

Internal hæmorrhoids may exist for a considerable time without the patient's knowledge; in fact, until the dilated veins have assumed a sufficient size to prolapse beyond the external sphincter muscle, little more than a fullness, aching and bearing down after stool being noticed, as the veins up to this stage in the development of the trouble still retain in great measure their tonicity, and are able to empty themselves and properly perform their functions. Should this over-distention of the veins continue, their coats will lose this tonicity, will fail to empty themselves, and thus remain permanently dilated; we will then have occurring the prolapsus, not only at, but between stools.

This prolapsing mass, coming directly in contact with the external sphincter, will engender in that involuntary muscle a marked irritability; in fact, will convert it into an involuntary muscle; and, sympathetically, the internal sphincter will be similarly affected. Under these circumstances what conditions will be presented? The hæmorrhoidal veins, being devoid of

valves and obliged, by their muscular coats, to support the column of blood, are held tightly in the grasp of these two muscles and their circulation is greatly impeded. Then, in turn, will follow semi- or complete strangulation with sloughing, until we have practically a fibrous tumor resulting.

Such pathological changes are, of course, directly traceable to pre-existing conditions,—constipation, straining at stool, straining against an empty rectum, retained fæcal matter within the rectal pouch, growths, malignant or benign, in the rectum, obstruction of the portal circulation resulting from disease of the liver, abdominal tumors, and, in the female, pregnancy and displacements of the uterus,—any one of which conditions will cause an interference in the hæmorrhoidal circulation.

Having thus, in a very brief manner, cited the causes of and the various stages in the development of a case of hæmorrhoids, the consideration of a typical case presenting for treatment will best serve our purpose. Bearing in mind that interference with the hæmorrhoidal circulation, from whatever cause, is the starting-point of all these pathological conditions, we would naturally look for some means to remedy the same. If traceable to growths within the rectum or abdominal cavity, their removal, if possible, is imperatively demanded; if to a displaced uterus, such displacement should be corrected; if to constipation, due to atony of the bowel or rectum (for, of course, any of the above-mentioned conditions may also produce constipation), the properly selected remedy, hygiene and exercise are essential adjuvants to the surgical interference.

Locally, our first object should be to relieve the obstruction to the circulation caused by the sphincteric irritability. How shall this be accomplished? Authorities upon rectal surgery have devised and recommended for this purpose various instruments: the bivalve speculum, bougies of metal or rubber, hollow bougies to be alternately filled with hot and cold water, etc., all of which have undoubtedly proven useful in the hands of their inventors. Some years' experience in their use has not favorably impressed me, more satisfactory results having been obtained by digital manipulation. Again, not having the finer sense of touch transmitted through the handle of an instrument that is given us when using the fingers, the opportunity afforded one to judge as to just the amount of dilatation

necessary without permanently destroying the usefulness of the muscle makes this method preferable, for a distention of the muscle to the point that would produce a laceration of its fibres is not only unnecessary, but attended with many annoying consequences. In fact, I am thoroughly convinced that incontinence will more surely follow a bad laceration of the muscle than its complete division by the knife. Our object, therefore, is not to paralyze the muscle, but rather to destroy its irritability, leaving it still abundantly able to perform its physiological function. The destruction of this irritability is, I believe, obtained by simple nerve stretching, and can be readily accomplished by carrying the dilatation to a point at which our sense of touch tells us the muscle is about to give way; in other words, we are sensible of the fact that there is about to occur a solution of continuity of its muscular fibres. To carry the manipulation beyond this point is, in my experience, unnecessary, the advice of the standard text-books to the contrary notwithstanding.

It has also been recommended that, in conjunction with the instrumental dilatation, a massage of the muscle should be given, and its complete paralysis induced. Such a pronounced traumatism cannot fail, in the majority of cases, to permanently affect the usefulness of the muscle, and will certainly accomplish nothing more in the direction of relieving its irritability.

The anæsthetic employed also plays a very important part. Complete narcosis induced by chloroform, ether, or any of their combinations, as is well known, produces relaxation of the muscular system, and when traction is made upon the parts we have nothing to guide us, the muscle being already in a state of flabbiness. An anæsthetic, therefore, that will produce complete insensibility to pain, and yet allow the muscle to retain in a great measure its resistance and rigidity, will give us the best possible chance to determine the point of sufficient dilatation with accuracy, and this ideal anæsthetic we find in nitrous oxide gas. Another point to be remembered is the manipulation of the muscle. Requiring, as it does, for its complete accomplishment, not over one and one-half minute, it is well to employ an anæsthetic that will quickly produce insensibility, and also permit of a rapid return to consciousness.

The patient having been placed in the Sims position and anesthetized, with the index, middle and third finger of each hand well lubricated, we commence our operation by the introduction of the index fingers, making gentle traction. As we feel the relaxing effect of such manipulation, the middle and third fingers are successively introduced and the traction continued with increasing force, its direction being midway between the antero-posterior and the transverse diameters, thus avoiding the coccyx behind and the pubes in front, and the tuberosities of the ischia on either side, in this manner obtaining the greatest possible amount of space in which to work. The divulsion having been carried to a point at which we feel the resiliency of the muscle about to give way, we finally, with the aid of the thumbs on the cutaneous surface, evert the entire pile-bearing inch, when the operation is completed. The pain and distress following such a procedure is so trifling that the patient will within ten or fifteen minutes be able to arise and go about his or her ordinary duties, the simple application of hot compresses two or three times during the succeeding twenty-four hours being sufficient to induce perfect comfort.

The patient being directed to report within the next two or three days, a marked change will be noticed in the appearance of the parts; the muscle is now perfectly relaxed, congestion entirely relieved, and in the great majority of cases prolapsus is a thing of the past, the circulation being no longer impeded. There will, however, be a marked flabbiness of the pile-bearing inch, due to the fact that the veins have not as yet regained tonicity, and without further assistance they would never be able to perform their functions properly. And just here can be demonstrated the satisfactory results obtained in the employment of the injection method. If a surgeon be called to attend a patient suffering from a fracture, he would first accurately adjust the fragments, and then keep them in position by a splint. Up to this point in our treatment we have only relieved the vein of its pressure and congestion, and we must now support its relaxed walls until they have regained their proper tone. The injection should therefore be made in the submucous tissue around the sheath of the vein, the object being to induce a slight inflammatory action, and the consequent throwing out of a plastic exudate completely encircling

and supporting the vessel—in very truth placing it in a splint. The injection, if made in the cavity of the vein with the hope that a coagulum will be formed and the vein obliterated, is not only unsurgical but particularly dangerous, we all being perfectly familiar with the grave consequences that might follow such a procedure; and it is for this reason that the profession, having been so long misinformed as to its application, have so bitterly condemned the method.

The character of the fluid used for injection is, I think, of far less importance than the precise manner of its application, *i.e.*, around the sheath of the vein, and never into its cavity. Any fluid that will superinduce a mild inflammatory action will produce the desired results. Ergot fluid extract with phenic acid and glycerine; weak solutions of phenic acid alone, from 1 to 10 per cent.; phenol, 15 to 40 per cent., have all proven satisfactory in my hands, the least distress, if any, following the use of the phenol, though the progress made will be less rapid. The fluid as well as the syringe and needle should always be absolutely sterile. Before making the injection, the tumor to be treated should be thoroughly cleansed with bichloride 1-4000. If, following the divulsion, there should at any time be a prolapsing tumor, which, however, rarely occurs, never inject the same until after it has been replaced within the rectum, as the manipulation required to effect such a result after the injection has been made will greatly intensify the inflammatory action, and cause pronounced discomfort. There should never be more than one (at most two, if the tumors are small) injections given at any one treatment, if the patient is to enjoy the greatest degree of comfort; and, unless the tumor be a very large one, it is rarely necessary to treat it more than once. An interval of from three to five days should elapse between the treatments, unless the patient be particularly sensitive, when it is often well to give them a rest of a week. According to the size of the tumor, from three to five drops of the fluid will be found amply sufficient, and should be injected slowly, the ordinary cases requiring from three to five weeks to effect a cure. The use of a cylindrical speculum will be found most convenient, the relaxed anal fold and mucous membrane being held out of the way, the tumor prolapsing directly into the end of the speculum, thus giving an unobstructed view.

Now, what advantage can be claimed for the injection method over radical surgical interference?

First, consider the mental effect upon the patient. Cases that can be treated to a successful conclusion by this method will constitute more than 75 per cent. of all those presenting themselves for treatment. We are well aware of the horror conveyed to the mind of the average patient by the word "hospital;" therefore, when we can say to such an one, "You can be relieved without submitting to etherization, operation by the knife, clamp and cautery, or ligature, and have substituted, instead, a practically painless treatment, perfectly safe, and during the period you are receiving the same are not only permitted but enjoined to follow your usual vocation, which in no manner will interfere with the ultimate result," we will most certainly relieve in a great measure the anxiety that would otherwise exist.

Again, from a physiological standpoint, what can be offered in its defence? A radical operation means a partial destruction of the anatomy of the parts; for, of necessity, a large portion of the circulatory apparatus must be sacrificed, and, consequently, the extra work thrown upon the remaining vessels will in time impair their vitality, and a recurrence may, with a fair degree of certainty, be expected. On the other hand, the patient cured by the injection method will leave your office with every portion of the hæmorrhoidal plexus of veins performing their normal function, and can truthfully be assured that by reason of this very fact there is much less liability to a like trouble presenting itself in the future.

In conclusion, permit me to call special attention to the following points:

1. Never inject into the cavity of the vein.
2. Never inject an external hæmorrhoid or an anal fold.
3. Never inject a mass protruding beyond the sphincter until it has been replaced.
4. Always destroy sphincteric irritability, thereby establishing free hæmorrhoidal circulation before employing the injection.
5. Do not inject more than two tumors at any one treatment, if the patient is to enjoy the greatest degree of comfort.
6. Caution the patient, during the course of treatment, especially to guard against straining at stool or against an empty rectum.

THE EARLY RECOGNITION OF PULMONARY TUBERCULOSIS.

BY F. MORTIMER LAWRENCE, M.D., PHILADELPHIA.

(Read before the Wm. B. Van Lennep Clinical Club, June 4, 1901.)

WITH the optimism concerning recovery from consumption which has arisen among physicians in recent years, there comes an added responsibility. Pulmonary tuberculosis is curable, we say—but when? Surely not with any regularity when a secondary streptococcic infection has occurred, when suppuration has begun, when cavities have formed—when, in short, any intelligent layman can diagnose the disease. Our hopeful outlook is based, as you all know, not upon our ability to overcome such conditions as these, but upon our knowledge that in the stage of infiltration, before the period of tissue disintegration, virtual recovery is not only possible but very common. As a famous clinician has stated, formerly our anxiety was to prevent our phthisical patients from becoming tuberculous, but now it is to prevent our tuberculous patients from becoming phthisical. In other words, we must aim to prevent the process of wasting which ensues upon the infective process. We must discover the oncoming disease in its very incipency if we are to battle with it successfully. Yet how easy it is to be careless. For example, how many of us examine even in routine fashion the chest of every patient who has a rather obstinate cough, or anemia, or “malaria”? Do you know that more than half of the patients who came into the wards of Hahnemann Hospital last winter with a history of intermittent fever were proven, by failure to find the malarial plasmodium and by success in discovering the physical and bacteriologic evidences of the pulmonary infection, to have tuberculosis? It is a fact. Moreover, besides those of us who become careless there is another, and I fear a large class of practitioners, who, even in these modern days, look upon physical and microscopic diagnosis as a rather unnecessarily refined phase of practical medicine. Perhaps they are not to be blamed; possibly it is teachers of clinical diagnosis who are to be condemned for

allowing men to enter upon practice without an adequate knowledge of physical signs and microscopic technique; but, at any rate, it is an unfortunate fact that such practitioners exist.

It is because of these things, and not because I have anything new to offer you, that I have decided to review briefly to-night the means at our disposal for the early recognition of pulmonary tuberculosis. The evidence varies in its character; it may be symptomatic, microscopic, or confined to physical signs, and the best diagnosis is the one based upon all three. First of all, however, let me insist upon the importance of the patient's history. Whatever may be our ultimate decision as to the consumptive heredity, we should always ascertain whether there has been any prolonged contact with a tuberculous subject. Then come the symptoms. Those of the earliest stage include cough, blood-spitting, fever and anæmia; but, unfortunately, not one of them, nor even a combination of all, is necessarily pathognomonic. In the popular mind hæmoptysis is nearly so; but if we stop to think of the many possible causes for this symptom we realize how unreliable a diagnosis based upon it alone must be. It is my own impression that fever of intermittent type is of far greater diagnostic importance than any other single sign. In suspicious cases, in which the other evidences of active disease are not conclusive, I provide the patients with a clinical thermometer and secure a written record of the morning and evening temperatures for a period of a week or two. Should the evening temperature rise more or less regularly to a point above 99° F., I feel little doubt as to the cause therefor. In addition, I am beginning to think that a persistent sub-normal temperature, ranging from 96° to 98°, is of almost equal significance; while a combination of the two, *i.e.*, a temperature sub-normal in the morning and slightly elevated in the evening, is completely characteristic. A pulse acceleration of 10 or 20 beats per minute, with diminished tension, has been noted in many cases. A widely dilated state of the pupils has also been regarded as an early sign of tuberculosis; but its significance is probably no greater than that of any other single symptom.

In connection with these symptoms it may be well to mention the diagnostic use of tuberculin injections. For a number

of years this test has been used by veterinarians for the detection of tuberculosis in cattle; and within a short time a number of enthusiasts have been applying it to their human suspects. The injection of one or more mgm. of the old tuberculin of Koch is followed in the tuberculous within eight or ten hours by a rise of temperature, together with active symptoms about the local focus in the lung. To my mind, the latter fact alone justifies the widespread unpopularity of the procedure. Any agent which can irritate latent tubercles into active inflammation is a deadly peril to the patient.

Microscopic methods for the detection of tuberculosis are applied, of course, to the sputum. I have no new suggestion to offer. The old method, used before the days of the bacteriologist, was to boil a little of the expectoration in a test-tube, with an equal quantity of caustic soda solution, for a few minutes, then sedimentate it, and examine for the curling fibres of connective tissue. Even discovery of the tubercle bacillus possesses little greater significance, and in some cases in which the very abundance of the sputum renders it difficult to find the bacteria, the presence of elastic fibres in areolar arrangement confirms our diagnosis. Unfortunately, however, their presence means tissue destruction, and our object is to recognize the disease before the latter has occurred.

To search through successive slides for the elusive tubercle bacillus has, doubtless, often fallen to your lot. Its discovery renders diagnosis positive; its absence leaves the question open. The common method, boiling the spread in the Ziehl-Nielsen solution of carbol-fuchsin, decolorizing in nitric or sulphuric acid, and counter-staining with methylene blue, meets every clinical requirement. I have had so much trouble with Gabbett's solution, which does not always keep well, that lately I have gone back to the use of the acid and the stain separately. Simple as the method is, errors are possible. Perhaps the most common is the result of insufficient decolorization, through which other objects than the bacillus are permitted to retain the red stain. By using a $33\frac{1}{3}$ per cent. solution of nitric acid, and allowing this to flow over the spread until it comes away clear, every object except the bacillus is completely decolorized. Even more annoying is our failure to find the bacillus when we have reason to believe it present. This is

often because the specimen of sputum did not come from the chest at all. Always instruct your patient to bring a specimen raised from deep in the chest, and for this purpose that first expectorated in the morning is best. Moreover, be careful to pick out for examination the small, cheesy masses; and in order to do this it is well to place the sputum over a dark background. In some cases there is no expectoration at all, and it has been recommended—Cabot, in his recent book, is one of the latest to do so—that we administer 5 or 10 grains of potassium iodide three times a day, or that we have the patient inhale some such irritating vapor as creosote, in order to stimulate expectoration. Personally I am opposed to this practice; the large râles thus produced afford evidence only too positive of the process of congestion and softening induced by the drugs.

So in many cases we find that we must, after all, depend upon the physical signs for our diagnosis. What are the evidences which we can reasonably expect to find in even the earliest stage of pulmonary tuberculosis? Recall what the condition is: a few tubercular nodules, each perhaps the size of a pea, scattered through the lung substance, and a certain amount of inflammatory infiltration which, if I may use the word, stiffens the lung substance and impairs its elasticity. At first there is no solidification, no blocking out of air-vesicles; and, since there is no consolidation, there can be no dulness. Percussion, palpation and inspection fail us; but fortunately the ear can render aid. As we listen attentively we notice a change in the breath-sounds. Normally, expiration, while occupying as long a period as inspiration, is audible over lung tissue only during the first third of its period. But if the lung be inelastic, it expels the air quite slowly; and hence the expiratory sound is prolonged, it is higher pitched, and it is harsh. In short, we have broncho-vesicular breathing. Here, however, another difficulty may confront us.

As you all know, tuberculosis begins in a lower lobe perhaps once in 500 times, an overwhelming proportion of cases beginning at one apex. In consequence, our examination is usually directed to the region above and all over the clavicle in front and above the spine of the scapula behind. It was noted by Flint years ago, and by many others since, that the respiratory sound in the right supra-clavicular region may be

broncho-vesicular, and yet the lung be perfectly healthy. That this is often true cannot be questioned, but there is danger that in allowing for it we may be led into disregarding the evidences of disease. When we have reason, from symptoms or other evidence, to strongly suspect tuberculosis, I do not completely disregard this broncho-vesicular breathing. Rather would I withhold an opinion for a little while, in the meantime availing myself of such evidence as the temperature range and sputum afford, and noting from week to week the outline, marked carefully at the first examination, of the area under suspicion. If there occur a distinct increase in the extent of the latter, and of course if localized râles develop, disease must be in progress. It may be positively affirmed that in a normal chest a broncho-vesicular note does not occur immediately below the clavicle. Under any circumstances râles afford evidence of disease—generally, of course, of simple bronchitis, but, thus localized, practically only in tuberculosis. While many cases of consumption present no such adventitious sounds at first, persistent search will finally reveal fine crepitations or cracklings in the suspected area. Sometimes the latter can be brought out only by having the patient cough. Beware, however, of sounds produced by pressure of the stethoscope upon the chest wall; they are fruitful sources of error. Another sign often very suggestive of beginning tuberculosis is feebleness of the breath sounds. This may even render it difficult to decide as to the type of respiration; in such a case, let the patient hold his breath while you listen to his heart, and the deep breathing which follows will aid your investigation of the lung. At this period, interrupted, wavy, “cog-wheel” respiration may be of great significance if associated with other signs; but if it occurs alone it is not to be trusted, for it is extremely common in purely neurotic patients.

Happy should be the patient whose condition is discovered thus early. Only a few weeks may elapse before another stage has been evolved by increase of the tubercular deposits and inflammatory consolidation of the lung substance between them. Then there will be dulness on percussion, increase of vocal resonance and fremitus, and breath sounds that have become still harsher, with expiratory note still more prolonged, so that the respiration is distinctly bronchial in character. In

fact, the physical signs at this stage resemble those of an apical pneumonia; but, because solidification is rarely absolute, a trace of vesicular breathing remains, and the sounds are not purely tubular.

Of the next stage, with its moist sounds to indicate the beginning of suppuration, I will not speak. Before that is reached general symptoms should have directed attention to the chest, and the physician who has allowed his patient to drift thus far without a suspicion of his danger bears a heavy burden of responsibility. Recovery is still possible, though distinctly less probable. Keep ever in mind, therefore, the necessity for recognizing the disease in those newly affected; for while a certain proportion even of the latter, because of faulty resistance, cannot be saved, a decided majority, so statistics show, will recover under proper treatment.

In conclusion, let me summarize the more important of my assertions. They are as follows:

1. A history of prolonged contact with a tuberculous subject is of greater significance than one of heredity.

2. A persistent evening rise of temperature to a point above 99° should arouse grave suspicion. A persistent sub-normal temperature may possess equal significance. A temperature sub-normal in the morning and slightly elevated in the evening is completely characteristic of beginning tuberculosis.

3. No single symptom is pathognomonic. Dilatation of the pupils and pulse acceleration, to which attention has been directed recently, are suggestive but by no means diagnostic.

4. The tuberculin test is inadmissible because of its tendency to render latent tuberculosis active.

5. The presence of tubercle bacilli in the sputum coming from deep in the chest is final evidence of tuberculosis; their absence leaves the question open. Elastic fibres indicate lung destruction, usually tubercular.

6. In a majority of cases now, as in the past, our diagnosis must rest solely upon the physical signs.

7. The most important single physical sign in the early stage is a harsh and prolonged expiratory sound at one apex. Feebleness of the breath sounds is also an important sign.

8. The occurrence of adventitious moist sounds, indicating beginning suppuration, renders the prognosis distinctly less favorable.

AN ADDRESS DELIVERED TO THE PHILADELPHIA COUNTY MEDICAL
SOCIETY OCT. 10, 1901, DEFENDING THE BUREAU OF HEALTH
IN INSISTING ON VACCINATION AS A PREVENTIVE
OF SMALL-POX.

BY CHARLES W. KARSNER, M.D., PHILADELPHIA.
Assistant Medical Inspector.

Mr. President and Fellow-Associates in Medicine: In the discussion before us to-night I have been assigned the duty of defending the Bureau of Health in insisting on vaccination as a prophylaxis to small-pox, and I am pleased to think that I am addressing so many thoughtful, scientific members of the medical profession, who will weigh with critical scrutiny all that may be said on either side of this question. Preventive medicine courts investigation from scientific minds, and it is not to be presumed that in my limited time I shall reply to the attacks upon vaccination made by the ignorant or malicious, or whose basis rests upon misstatements or prejudice. Nor can I defend the use of impure virus, or an unsanitary technique in the operation. Probably our older members will readily recall the old-time doctor, with rusty lancet, the unclean arm, dirty clothing, and pus-laden crust or point. I think it a subject of congratulation that the antiseptic day in vaccination has dawned upon the medical world, but it may be many years before the old-time horrors are eradicated from the public mind.

I do not think it will be denied that there is a degree of vagueness or uncertainty concerning vaccination prevalent in the minds of many members of our profession. Ask a man, What is vaccination? What does it propose to do? Are you favorable to it? What is your experience with it? And note the variety of expression and experience. Now, while modern sanatory science accepts the theory and practice of vaccination as a prophylaxis to small-pox, I do not recall that I have ever seen the matter embraced in a clear statement of facts; hence, with your permission, I shall assume to place in debatable language such statement of the demand and claim of modern sanatory science concerning vaccination:

1. It demands that the operation be done with strict regard

to modern antiseptic surgical methods, and with a lymph free from foreign bacteria.

2. It claims that recent successful vaccination confers a practical immunity from the disease.

3. Remote successful vaccination modifies the susceptibility to, and the virulence of, an attack.

4. The character of the resultant mark will indicate the protective value, and in demonstration of these propositions I shall ask your careful consideration of the following facts, all of which may be verified by the public records of our city.

Through the heroic work and untiring energy of my distinguished friend and colleague, Dr. Wm. M. Welch, the literature of our profession has been enriched by a statistical record of five thousand cases of small-pox which have occurred in our Municipal Hospital from 1870 to 1894. This period includes one particular epidemic of considerable magnitude and great virulence, that of 1871 and 1872. The death-rate was particularly high, because at that time the removal of patients was not compulsory, and hence the hospital received, to a large extent, only the worst class of cases. This may be readily inferred from the fact that as many as 128 of these patients died in less than forty-eight hours after admission, while, indeed, some died even in the ambulances. The experience of Dr. Welch during these twenty-three years of labor are very conclusive in favor of the claims made by the modern sanitarian. Concerning the prophylactic power of vaccination, he says: "I have seen, over and over again, entire families brought into the hospital, when all the unvaccinated children have been suffering from small-pox and the vaccinated children remained unaffected. I have seen the former perish and the latter remain exempt from the disease, although living, eating and sleeping in the infected atmosphere for several weeks; but I have yet to see a single unvaccinated child escape the disease under similar circumstances. Furthermore, I have more than once seen a vaccinated infant draw its daily supply of nourishment from a mother suffering from varioloid, and the infant remain as free from any symptom of the disease as if the infection were a thousand miles away; and during my service of twenty-three years no resident physician, no nurse, laundress, cook, or any other employee who was properly re-

vaccinated before entering on duty has taken the small-pox." And this, my fellow-associates, will appeal to your minds as most convincing evidence, and is fittingly supplemented by that shown in the mortality tables so carefully prepared, a portion of which I have the honor to present to you for consideration:

Five Thousand Cases of Small-Pox.

	Admitted.	Died.	Mortality.
Variola,	2831	1534	54.18
Varioloid,	2169	28	1.29
Total,	5000	1562	31.24

Vaccinal Record.

Vaccinated in infancy, good work,	1412	124	8.78
" " fair " 	666	98	14.71
" " poor " 	1070	290	27.10
Total vaccinated,	3148	512	16.26
Unvaccinated,	1759	1027	58.38
Unclassified,	93	23	24.73
Total,	5000	1562	31.24

Age Period in Childhood—Under One Year.

Unvaccinated,	78	57	73.07
Vaccinated,	2	0	.00

One to Four Years.

Unvaccinated,	404	208	51.48
Vaccinated in infancy, good work,	10	0	.00
" " fair " 	10	1	10.00
" " poor " 	15	1	6.66

From the proportions observed in the above record it will appear that, had the 1759 unvaccinated ones been protected by vaccination, doubtless 738 lives would have been saved.

And, coming down to the present time, our experience thus far in the Municipal Hospital, during the present outbreak, is that out of over three hundred cases admitted they comprise only two classes,—the unvaccinated, and those vaccinated in infancy and now past puberty. There have been less than fifteen per cent. of deaths, which have occurred among the unvaccinated. There has been no case of a recently-made successfully vaccinated person admitted, nor a school child who has been successfully vaccinated within five years, and I will

give you the records concerning a few very interesting and instructive cases. Mr. C., wife, and six children, admitted. Parents had been vaccinated in infancy; both had varioloid. Four youngest children had never been vaccinated. All had unmodified small-pox. Two had reached school age and been vaccinated; these have not taken the disease, although exposed freely to it in the hospital for more than three weeks. Another Mr. C., wife, and three children, had never been vaccinated. Father and mother both died of unmodified small-pox. The three children were vaccinated when the disease was discovered; one has died, one has varioloid, and one has thus far escaped. Mr. C. W. S. lives in small house, seven rooms, eleven in family. Four, with him, had never been vaccinated. He went to the hospital on the 18th of last month, died on the 29th. All were successfully vaccinated on the outbreak of the disease except the mother, who refused. She has developed the disease, and is now under treatment. Thus far all the rest have escaped. Mr. G. has five children, all of whom sleep in one room; two were of school age and had been vaccinated; three were too young to go to school, had never been vaccinated. All three are now in the hospital with small-pox, while the two who were vaccinated are exempt. While on the subject of school children, permit me to recall to your minds the fact that in 1863, during the small-pox epidemic in London, Drs. Seaton and Buchannon examined over fifty thousand school children, and found in every thousand unvaccinated 360 with scars of small-pox; while with every thousand vaccinated, but one and seventy-eight hundredths had any trace of the disease.

I need not refer to the dreadful epidemics of the past, notably that of Mexico during the sixteenth century, except to state that at the meeting of the American Public Health Association, held at Indianapolis only last year, Drs. Salvador Gardiiego and Eduardo Liceago read papers affirming that small-pox had been practically stamped out of Mexico, owing to the protective power of vaccination, and that it is unknown among the vaccinated. It may be of interest to say that the Jenner method of humanized virus is used there—that is, the cow-pox from the calf has passed thousands of times through man, and, by a careful selection, has acquired its stability, and

the maximum of protective power as the result is claimed by these eminent sanitarians to be permanent.

Many other illustrations might be added to those already given to prove the power of vaccination to do what is claimed for it; but I hesitate to trespass further upon your time and patience, feeling confident that I have shown you by living, tangible, uncontrovertible proofs the beneficent influence of vaccination as a preventive and modifier of small-pox. I think I have conclusively proven every claim made by modern sanatory science. I have shown you that under its protective power the suckling infant may toy with this hideous monster; that the tiny school child, amid the multitudes of mixed race and life conditions, may pursue its studies unharmed by this horrible poison; that in the humble home and princely mansion, aye, that even in the pest-house itself, men, women and children may walk, eat, drink and sleep in a security that is practically absolute. I have shown you that even a nation may be freed from one of the most dreadful records of past centuries.

Homœopathy and vaccination were born in the same century. Both came to light under brilliant masters in the art of healing,—Samuel Hahnemann and Edward Jenner. And even the great Hahnemann himself acknowledged the power of vaccination, for in paragraph 46 of the *Organon* we read, “Cow-pox, having nearly attained its period of perfection, will, by its similitude, lessen to a great degree the virulence and danger of a subsequent eruption of small-pox;” and this illustrious man may well be excused for penning, as his first paragraph, “The physician’s highest and *only* calling is to restore health to the sick,” for in his enthusiastic devotion to the promulgation of his magnificent law of curative medicine he had failed to see in Jenner’s discovery the early indication of a great law of preventive medicine. Dr. Edward Jenner, a name which I am proud to link with that of Hahnemann, announced and demonstrated that disease can be prevented. *Hahnemann* and *Jenner*, two of the greatest benefactors of the human race! Through Hahnemann a law of cure. Through Jenner a law of prevention. And together these God-given laws have come down to us amid the storms and strifes of a century. I need not recount the battles. The story is ever fresh from constantly

recurring clashes at arms, and to-night one of these storm-tossed truths comes to us for judgment, and I have the honor to bespeak for it such cool, calm, deliberate consideration as befits members of a noble profession, whose only decision should be based upon cold, scientific facts, and the need of our common humanity.

OBTURATOR HERNIA, WITH A REPORT OF TWO CASES.

BY H. L. NORTROP, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Pennsylvania, Pittsburg, Sept., 1901.)

BECAUSE of its rarity, because of its difficulty of diagnosis, and because of its high mortality, obturator hernia deserves our most careful and serious consideration. It is one of the many causes of acute intestinal obstruction, and, considering the small number of cases, such obstruction is produced by it with far greater relative frequency than by any other form of hernia. It may thus be very properly considered synonymous with bowel obstruction, for in nine cases of obturator hernia out of ten we must deal with this dire condition.

In regard to the rarity of obturator hernia, it is a noteworthy fact that only thirty operated cases were recorded in Europe up to 1896. Sir Astley Cooper,* in 1802, had never seen an obturator hernia; and so far as he was informed at that time an operation for its radical cure had been performed but once. Anderson† has reported two cases, with one death. Godlee‡ reports three operated cases, all women, and all ending fatally. Elder§ operated upon one case of obturator hernia (Richter's), female, age 73 years, which recovered, and left the hospital on the twenty-first day after the operation.

Obturator hernia is a protrusion of small intestine or omentum (I can find no record of any other abdominal or pelvic organ being involved) through the potential opening, or weak spot, in the obturator membrane, beneath the horizontal ramus of the pubic bone. Through the normal deficiency in the

* Sir Astley Cooper's *Anatomy and Surgical Treatment of Abdominal Hernia*, p. 324.

† *London Lancet*, April, 1896.

‡ *London Lancet*, June, 1897.

§ *Annals of Surgery*, vol. xxxii., p. 235.

membrane the obturator artery, vein and nerve pass, and the canal, about two centimeters long, is directed forward, downward and inward. These vessels and nerve must necessarily be intimately associated with a hernia at this point.

The rupture, having carried the obturator fascia with it, will lie outside of the pelvis between the obturator membrane and the obturator externus muscle, or between the latter and the pectineus muscle, with the adductors longus and brevis on the inner side. Thus we see that it is of the interstitial variety of herniæ. The femoral vessels, resting upon the pectineus, will be situated in front and to the outer side of the hernial tumor. The obturator vessels and nerve are found either to the outer or the inner side of the sac at the obturator ring, or the nerve may be in front and the artery behind the sac. Their position varies greatly, which is one of several good reasons for abandoning the older operation of attacking the hernia by going through Scarpa's triangle. In fifteen cases collected by Vinson,* they were found to the outer side in six, to the inner side in six, and behind the sac in three.

Because of the variable position of these structures, no one method can be formulated for the division of the neck of the sac; though, if it be approached from in front, the operator is in the safest position. The older authorities advised the division of the sac upon its inner side because the vessels and nerve were supposed to be placed upon the outer side in the majority of cases. A careful examination of reported cases, however, will show that this was poor advice, inasmuch as the vessels are found to the inner side with equal frequency. Formerly, the neck of a hernial sac was divided under cover and out of sight with a herniotome, now almost an obsolete instrument. We are living in the days of open surgery, where the surgeon cuts and divides under the guidance of the eye as much as possible and not so much in the dark; he is not so dependent upon his knowledge of anatomy as he used to be; now he sees, or endeavors to, whereas formerly he worked more in obscurity. Obturator hernia occurs mostly in the female sex. Out of sixty-three collected cases, fifty-nine were in women.† Agnew‡ says

* Nelaton's *Elémens de Pathologie Chirurgicale*, vol. iv., p. 403.

† Dennis' *System of Surgery*, vol. iv., p. 213.

‡ Agnew's *Surgery*, vol. i., p. 605.

it is rare under 45 to 50 years of age. Keen and White* regard it as seldom occurring before 50 years. Coley† makes it belong to past middle life, and finds that the average age of fifty-three cases was 61.8 years. Richardson‡ devotes a little more than four lines to the whole subject, and states that obturator hernia usually occurs in stout women advanced in years.

The symptoms of obturator hernia are, as previously noted, those of strangulation, since it is rarely recognized before obstruction supervenes. We have, therefore, the symptoms of bowel obstruction, to which may be added pain along the inner side of the thigh and in the hip- and knee-joints, due to pressure upon the obturator nerve at its point of exit from the pelvis; and there may be a fullness—slight, probably, if present at all—in the upper inner part of Scarpa's triangle. The sensitive neck of the tumor may sometimes be felt by a vaginal or a rectal examination, but an extra-pelvic tumor is extremely rare. Richardson declares that the diagnosis is impossible without the presence of an external tumor. Woe to the surgeon who waits for either obturator pain or tumor. Fortunately, the surgery of to-day demands an early intra-abdominal exploration in cases of obscure obstruction, that the cause of obstruction may be promptly determined and located. This is the way in which many obturator herniæ are discovered.

While it may be possible to reduce an obturator hernia, a correct diagnosis of such having already been made, taxis is an ill-advised method of treatment, because, even if successful, it is impossible to make adequate and effective pressure against the obturator opening by means of a truss pad. Therefore the hernia will recur. Because the potential ring is small and its margins unyielding (they consist of bone and a tightly-stretched, strong, fibrous membrane), and because the structures anterior to this part of the pelvic wall are firm and substantial, a large protrusion is next to impossible. And by the same facts are explained the frequency of strangulation and of the Richter hernia, or partial enterocele.

The treatment of obturator hernia must therefore be operative. How shall the operation be done? Either from below,

* *American Text-Book of Surgery*, p. 807.

† *Ibid.*, p. 807.

‡ *Surgery by American Authors* (Park), vol. ii., p. 417.

reaching the hernia by incising parallel to and to the inner side of the femoral vein, going between the pectineus and adductor longus muscles; or, preferably, opening the abdomen in the median line or in the right or left linea semilunaris, and attacking the point of constriction from within. The latter is the preferred route, because it enables the operator to deal more directly and easily with the parts concerned in the trouble. It is the usual method employed to-day, although Godlee* advocates interference both from below the pelvis and through the abdominal wall, as giving the operator the best opportunity to meet the emergencies possible under the circumstances.

CASE I.—Mrs. C., age 68 years, was operated upon in May, 1900, for a right-sided femoral hernia. Complete recovery followed, and she enjoyed good health until May 26, 1901, when she became constipated, and suffered severe abdominal pain and frequent vomiting. Her bowels did not move for four or five days. A diagnosis of bowel obstruction had been made by her physician, in corroboration of which I found the following condition: anxious facial expression, heavily coated tongue, persistent nausea and frequent vomiting of mucus and bile, severe pain in right lower quadrant of the abdomen, slight distention of abdomen which was tympanitic to percussion and also quite tender. There was no rigidity of the abdominal muscles. Temperature, 97.8°; pulse, 68. A short, linear scar was noticed in the right inguinal crease, the result of her operation for femoral hernia one year previously. There was no tumor to be found in umbilical, inguinal or femoral regions. There had been no pain in the thigh, and there was no fulness or increased resistance in either of Scarpa's triangles. My diagnosis was acute bowel obstruction, due, probably, to adhesions or some trouble at the right femoral ring, the seat of her old hernia.

I operated in twelve hours from the time I first saw her (consent was not given before), making an incision four inches long in the right linea semilunaris, extending it down to the inguinal ligament. I found the peritoneal cavity to contain a considerable quantity of free, thin pus, in which floated a number of fibrinous flakes. The peritoneum was intensely injected, while

* *Ibid.*, p. 417.

the coils of the ileum immediately beneath the incision were collapsed, covered with fibrinous material and matted together. While liberating these coils, several ounces of pent-up pus were evacuated. Searching for the seat of obstruction by breaking up newly-formed adhesions in the pelvis, I was surprised by an escape of liquid feces. This was presently found to be pouring out of a circular, punched-out opening nearly the size of a dime, with ulcerated edges, and surrounded by inflamed, friable bowel wall. I quickly closed this perforation with fine silk and traced the bowel to the right obturator ring, through which it had passed out of the pelvis. By gentle, persistent traction it was liberated from this vise-like constriction, when it was found to be dark in color and bordering on a gangrenous condition. Nearly three inches of the ileum, a complete loop, had been protruded through the obturator opening. The vitality of this segment was very much impaired, but it showed signs of possible recovery; and as the patient's general condition was far from good, I packed the wound with iodoform gauze and hurried her to bed. She died in forty-eight hours.

CASE II.—Mrs. L., age 41 years, tall and very thin, was seized with abdominal pain while putting a roast of beef into the oven. This pain “felt like a butcher-knife cutting her in ‘the privates,’” and also extended down the inner side of her thigh as far as the knee. She began to vomit at once—I say “began,” for she kept it up for six days—vomiting food, purgative medicine, bile, etc., which, after two or three days, had a fecal odor. Purges and enemata were administered, but no bowel movement occurred for six days—not until after her operation. Acute intestinal obstruction, high up, was diagnosed by her attending physician.

In addition to the symptoms just enumerated, I found a moderately distended abdomen, somewhat tender over the right lower quadrant; and by most carefully comparing one side with the other, I detected a slight, but positive, increased resistance high in her right Scarpa's triangle. This same area was also somewhat sensitive. There was no tumor. Diagnosis, obstruction of the bowels, due to a right strangulated obturator hernia.

I operated upon her as soon as preparations could be made, making an incision in the right linea semilunaris down to the margin of the pelvis. The peritoneum appeared normal. I at once sought the obturator region upon the right side, and

found the ileum caught in the ring. By making gentle traction from within, and pressure or taxis from without in Scarpa's triangle, I was able to liberate a Richter hernia which evidenced a considerable degree of strangulation. Under the application of hot water the darkened bowel wall was resuscitated, and the abdominal incision was sutured except at the lower end. I made no attempt to radically close the obturator opening other than by inserting a piece of iodoform gauze down to its mouth, through the lower angle of the wound, to bring about the formation of adhesions and granulation tissue, thus hoping to effectually seal it and secure the neighboring intestinal loops from further protrusion. The gauze was allowed to remain *in situ* for one week. This patient made a complete recovery, her wound healed by first intention, and she was discharged cured in twenty days.

In conclusion, let me emphasize the importance of a careful, comprehensive, complete examination of cases of bowel obstruction, with a determination to arrive, if possible, at a correct diagnosis of the cause early in the disease or attack. If this special, systematic effort be made to determine the cause, many obturator herniæ will be diagnosed, if not before strangulation, at least before operation. Let it be remembered that bowel obstruction belongs to the domain of surgery; that bands of adhesions, hernial rings and constrictions, malignant neoplasms, etc., are not miraculously melted away by internal medication, nor by the use of atropine, subnitrate of bismuth, etc., as some would have us believe, and to which attention has frequently been called of late.

I would advise the selection of the abdominal route in attacking an obturator hernia, combined, when circumstances necessitate it, with a secondary incision through Scarpa's triangle.

Evidently no one has deemed it advisable to seriously suggest a radical closure of the obturator ring, either from below or from above. "Discretion is the better part of valor," after which we must confess that while the sac of an obturator hernia may be ligated, the ring itself cannot be satisfactorily and easily closed. The gauze pack, however, will isolate the ring from adjoining intestinal loops, and thus by adhesions we may be able to seal the opening and bind the intestinal coils together sufficiently to prevent further herniæ at this point.

A CASE OF PELIOSIS RHEUMATICA WITH ERYTHEMA EXUDATIVUM
(SCHÖNLEIN'S DISEASE).

BY CHARLES E. GREER, M.S., M.D., CHARLESTON, ILL.

(Ex-Interne Cook County Hospital, Chicago, Ill.)

PELIOSIS rheumatica is one species of the general arthritic form of purpura. It is characterized by a sore throat, moderately high fever, multiple arthritis, and a purpuric eruption which usually appears about the affected joints. This eruption may, however, be an urticaria or an erythema exudativum, and under the latter circumstance the disease is sometimes confused with erythema nodosum. The disease usually attacks young people between the ages of twenty and thirty years. The pains affect the ankles, knees and wrists, but may affect all of the joints and even involve the muscular system as well. Rarely do the rheumatic symptoms become generalized, but the heart may become involved, and there may be a genuine endocarditis or pericarditis, which of course renders the case a great deal more serious. In some cases œdema of the cellular tissue is marked, even to the extent of producing a pemphigoid eruption. The urine is diminished in quantity, the amount of urea is below normal, and sometimes a small amount of albumin is present.

Peliosis rheumatica usually appears in persons of rheumatic taint. Nervous exhaustion, privations, exposure to cold or sudden chilling of the surface are among the exciting causes. The prognosis is usually good, unless some serious purpuric or rheumatic complication sets in. Ordinarily it will run its course in from ten days to two weeks.

Treatment.—The ordinary hygienic and other precautions usually taken in rheumatism should be observed. Keep the bowels and kidneys acting freely with a mixture of equal parts of Rochelle salts and potassium bitartrate. If the skin is dry and harsh, bathe it well in tepid water, follow by brisk friction with a rough towel, and then rub in enough olive oil to keep it soft and active. Let the patient avoid sitting in a draught

or getting chilled. Give anti-rheumatic remedies internally, such as rhus tox., bryonia, guaiacum and salicylate of soda.

As cases of this disease are comparatively rare in homœopathic literature, perhaps the report of one will be of interest to the profession.

On June 17, 1901, a young man entered my office with the following history: He was twenty-three years old; excepting the use of tobacco, he had good habits, and denied venereal history. Father and mother died when the patient was quite young, so he knows nothing about them. Two sisters are living and well. The patient had had the usual children's diseases, and also had two large abscesses on the left thigh, which discharged some small pieces of bone. He does not know the cause of the abscesses. There is no evidence of joint trouble now. In 1898 he had an attack of muscular rheumatism, which continued for a short time, but was not very severe.

Present History.—Patient has not been feeling perfectly well since December, 1900. At times he would ache all over his body, he had sore throat frequently, his appetite varies, his bowels are always constipated, and he never feels like working.

Four days previously, while digging post holes on a very warm day, he became quite hot. In the evening, although the atmosphere was still warm, he felt chilly and put on his coat. The next morning he had a sore throat, felt sore all over his body, back and legs ached, his hands, wrists, ankles and knees were stiff and pained him quite a great deal, especially the knees and ankles, and he noticed an eruption on his wrists. Pain was very severe when walking. Several chilly sensations were followed by high fever. The urine was scanty.

On presenting himself at the office he had a temperature of $102\frac{3}{5}^{\circ}$. Tonsils and pharynx were congested, the tongue was slightly coated white, and on the dorsum of the left hand and wrist were numerous pink elevations varying in size from about that of a pea to that of a three-cent piece. This eruption had well-marked edges, was indurated and elevated, and the color disappeared on pressure, but immediately returned. On the right wrist several had joined together, making a patch about two inches square without any intervening spaces. This same eruption appeared on both cheeks, feet and ankles, and

the latter were so swollen that a shoe could not be worn. The eruption did not burn, itch or smart, but felt a little sore, as if bruised. All pain was confined to the joints, but the muscles of the legs and thighs were stiff and ached. Heart, lungs and abdominal viscera were normal. The urine was slightly albuminous, diminished in quantity, of high color and 1016 sp. gr.

Differential Diagnosis.—The only disease for which this might be mistaken is erythema nodosum. In it, however, there is no congestion of the pharynx, tonsils or fauces, the temperature is not so high, and rheumatic symptoms are not so prominent.

Diagnosis.—Peliosis rheumatica accompanied by an erythema exudativum.

Treatment.—A tepid bath was followed by brisk rubbing and inunction of olive oil. Bowels and kidneys were kept active by means of teaspoonful doses of Rochelle salts and potassium bitartrate, equal parts, three times a day. The patient was ordered to remain in the house, keep quiet, and avoid becoming chilled. On account of the congested tonsils and pharynx with marked rheumatic symptoms, the patient was given guaiacum 1x every two hours, with a five-grain powder of salicylate of soda four times a day.

On June 22d he reported himself better in every respect, with throat well, eruption fading, and pains better. Guaiacum was discontinued and rhus tox. 3x substituted. In five days more he was perfectly well.

THE EFFECT OF PODOPHYLLIN UPON THE URINARY SECRETION.—William Bryce, M.D., writes very entertainingly upon some of his personal experiences of the action of our remedies in the *Journal of the British Homœopathic Society*. He refers to the case of a gentleman, aged 63 years, who sent him, for examination, a bottle of urine. The doctor could find nothing wrong with the urine except that it had no color. He then examined the patient and found him to be in good health. The patient complained that he was passing large quantities of urine. Measurement showed that the daily amount reached as high as eighty ounces. During one *night*, from 10 P.M. until 6 A.M., this patient voided *sixty ounces*. Dr. Bryce attributed this condition to the effects of *Podophyllin* 3x, which his patient had been taking, and adds that he has observed the same effect from low dilutions of this remedy, hundreds of times. When a similar condition exists, idiopathically, the author has never once seen the *twelfth* dilution of *Podophyllin* fail to remove it.

EDITORIAL.

QUACKERY.

EACH year the struggle for existence seems to become more desperate, giving rise to a hitherto unknown sharpness of competition, which pervades every sphere of life. Nowadays to to live is to fight; to fight for every inch of vantage-ground; first to gain it, then to keep it. Not only in commercial pursuits, where it seems most called for and most readily accepted as natural and legitimate, is this eager spirit of competition rampant, but even in professional spheres the results of its promptings are every day more evident. The world seems to have become too full of workers in every line of activity. While machinery of all kinds has lessened the demand for workmen, every day increases their numbers. The demand for new foreign markets is heard on all sides, and to gain them resort is had to all sorts of devices—cheapening the wares, introducing new ones and decrying the old ones, and developing new wants and necessities.

The same is true where the wares offered are of a more intangible sort. Look at the increase in the number of churches, and the division and subdivision of the ecclesiastical world into sects. Almost every phase of religious thought must have its own representative, Rev. Somebody, who offers his particular brand of doctrine to his own band of followers in his own chapel. His wares are far superior to any to be obtained at the old stand, for they supply a want which, if not yet experienced, will in the future prove to be a serious defect in their title to mansions in the skies. The devices used to bring these wares to the notice of the public who are to support those who offer them are as varied and as flamboyant as are the posters which advertise some new brand of health coffee or some strengthening elixir. Competition is everywhere, and leads to quackery. By blackboards in the pulpit, by pennies distributed to represent talents, by better choirs and louder music, by

genuflexions and vestments and candles without the warrant of tradition, by bazaars and progressive euchre parties under the auspices of a church, and by a hundred other devices, it is sought to draw undying souls away from the church around the corner to the only place where they can obtain all that they need for the present and for the future.

While the legal profession has not been able to employ exactly the same means in the competitive struggle for existence by its members, the advertisements of legal advice free, divorces obtained without publicity, claims in estates prosecuted on contingent fees, and such like, shows that the same spirit is present.

In the medical profession—alas! that we should be obliged to confess it—we have everywhere around us glaring evidences of the prevalence of the same spirit of competition, prompted, not by the desire to promote the true welfare of mankind and the betterment of his present physical condition, but by a greed for the shekels of the gullible public. The public desires to be humbugged, and, by a species of auto-suggestion, has put itself into a condition to have its desire gratified. By thinking of itself and of its health, and through the fostering care of Boards of Health, and by uncalled for ventilation of medical subjects in the public press, coupled with the instinctive desire for a clean tongue and no aches, the dear public has come to regard itself as a chronic invalid. It has learned that it has kidneys, and, although their exact location is often a matter of hazy uncertainty, they know they are not in front; and therefore, if anything is felt behind its back, Bright's disease surely threatens. If it does not know that it normally possesses an appendix it is not from want of hearing about it, and every ache in front brings with it the terrors of appendicitis. The acid in its blood, the malaria in its system, the torpid liver somewhere or other in its body, the disordered or impaired sexual organs, and the thousand and one other possible sources of discomfort, ill health and much-dreaded death, are so constantly and persistently being brought to its notice that it offers itself a ready prey to any one who is willing to make use of its anxiety for his own selfish ends. The temptation to do so has proved too strong for many, and the result is an alarming spread of quackery, open and veiled, without and within and on the border-lines of the medical profession.

In spite of the optimistic views of some that there are as good chances of success as there ever were for exceptionally good physicians, and that there is always room at the top, statistics prove that the profession is overcrowded, at least below, while the raising of the standard of medical education and the more general scientific training in the profession have brought about a very considerable encroachment on this supposedly roomy height. This condition naturally brings with it fierce competition, and this, with the mental attitude of the public, has fostered the excessive growth of quackery. It is appalling to conjure up the various forms in which this appears, and it is impossible to enumerate them all. To say nothing of the various incorporated medical remedies advertised so extensively and dispensed so freely after free medical examination by graduates of medical colleges in good standing, we have more ambitious schemes, founded upon some particular cult, which promise relief when all others fail. We naturally think of Christian Science and its wealthy prophetess; the Faith Cure, Osteopathy, etc., etc. All have as their foundation some partial truth, upon which rests their ability to gain adherents; but their claims and the manner of heralding them write them down as systems of quackery.

In the public prints are constantly cropping up indications of but little known and obscure systems of cure, generally in the reports of the coroner's investigations. We lately thus became acquainted with the existence of a society of followers of a Vital Physician who claims to be instructing twenty-three students, and to have treated 2386 cases during the past year with only 1 death, the case of the one being investigated, which had been treated with persimmons, seckel pears, parsley and sage, and the milk from a black cow.

Not long ago starvation as a means of cure was in the same forcible manner brought to the notice of the public.

Much more pretentious is one of the latest claimants for popular favor, the Mechano-Neural Therapy. It has an Institute at Trenton, N. J., for the treatment of patients recognized as such, and a College for the graduation of others, after a ten months' course, which "offers to the prospective student an opportunity to acquire a broad scientific education, which fits him to practice his profession of Doctor of Mechano-Neural

Therapy." The late graduation of the first four students was an occasion of much rejoicing to all concerned, and with reason; for it was asserted, in an address to them, "A practice already awaits you. The demand is greater than the supply. Mechano-Neural Therapy is already known the width and breadth (*sic!*) of the land. It has created the greatest upheaval ever known to medical history." (We sadly confess our lamentable ignorance of any upheaval having taken place. There have been no signs of it here in placid Philadelphia; they were probably lost in crossing the Delaware.)

A statement made in regard to a new student is of special interest to us. It is said that this student spent two years in Hahnemann Medical College of Philadelphia, and "after having been in the Mechano-Neural College for three weeks, says he has learned more than he learned in his two years at Hahnemann, and regrets the time he wasted there." On inquiry we learn that the Faculty of Hahnemann always regretted the time he wasted while under its charge, and are glad that he has come to view his conduct in the same light. They had, however, no idea that he was quite as neglectful of his duties as his statement would make him appear; to be able to do in three weeks what he did not do in two years argues a bad past, but may point to a more hopeful future.

But quackery shows itself also within the profession in forms just as reprehensible. When a physician, taking advantage of temporary conditions, plays upon popular fears or popular prejudice in order to enter into more direct competition with his colleagues, he is guilty of quackery. A perfectly justifiable specialism may and often is pushed to the verge of quackery, even by those who are most bitter in their denunciations of more open quackery. Quackery does not lie alone in the boasting of a knowledge which is not possessed, but may consist in the illegitimate means used to herald knowledge and skill actually possessed. Reports of operations and opinions on cases of public interest, evidently prompted by the physician, come very near to quackery. At the present time, when, on account of the presence of small-pox, vaccination is being urged and enforced, we cannot but regard an attempt of any physician to appeal to the ignorant prejudice of some of the public against this prophylactic measure, while offering some substitute, the

efficacy of which has never been scientifically or statistically proved, as a well-defined species of quackery.

What are we going to do about it? To educate the public is, we fear, a hopeless task, since they cannot appreciate the ethical difference between the various forms of forbidden or allowable advertising and quackery. All that we can do is individually to avoid every appearance of evil, and to frown down any form of quackery wherever it appears, until the time comes—may the day be far distant—when the practice of medicine will become a trade, and all the tricks of trade be allowable for all. Then will the quack and the physician have equal advantages before the public, and brains, not wind, will decide success.

ANTITOXIN AND VACCINATION-TETANUS.

MUCH consternation has been created by the reports in the daily press of a number of cases of tetanus following closely upon the use of antitoxin and vaccine. The facts bearing upon the cases produced by antitoxin injections seem to be as follows: In St. Louis, Mo., no less than eleven deaths from tetanus have resulted apparently from the use of a preparation of antitoxin furnished by the local Board of Health. It is stated that the serum was obtained from a horse which died one month later from tetanus. Other serum was taken from the same animal two days before the appearance of the tetanus, but this, it is claimed, was at once destroyed. To express an opinion concerning this sad occurrence is rather a delicate matter until a thorough investigation has been made. Still we think some comment is called for at this time.

No one will question that tetanus is an infectious disease, and that its germs were introduced into the bodies of the unfortunate victims with the antitoxin. But how the tetanus germs were introduced into the antitoxin is not so easy to decide. In view of the readiness with which the horse develops tetanus, it hardly seems likely that the animal in question could have had the disease at the time of the taking of the first antitoxin, and that it remained latent for an entire month. Other possibilities are far more likely, such as contamination by dust

or the use of improperly cleansed utensils. At any rate, a searching investigation has been promised, and we trust that the truth will be determined, and such accidents forever afterwards safeguarded. This accident has happened on but one previous occasion, in Italy. The cause of the contamination in this instance is unknown to us.

Aside from the loss of eleven lives, the St. Louis tetanus cases are unfortunate in that they will deter many from using antitoxin at all, and will cause numerous others to defer its administration until such a period in the course of diphtheria as to make it certain that no other hope remains. Thus many times eleven lives will be lost. When one studies the carefully-prepared statistics of the antitoxin treatment of diphtheria, and learns that this remedy has reduced the mortality to fifty per cent. of the former figure, and when he is told that 100,000 cases of diphtheria are thus treated annually, he can readily see how serious the question is. Admitting the worst concerning the dangers of antitoxin, and putting against it the *not less* than 10,000 lives annually saved by it in the United States alone, we see no reason why it should be discredited now.

The vaccine-tetanus cases are equally serious. Thus far about one dozen cases have been reported from the vicinity of Philadelphia. Of these, five were observed in Camden, N. J., one in Philadelphia, and the remainder in the suburban districts of Pennsylvania and New Jersey. Other cases have been reported in New England. With the exception of those occurring in Camden, the cases have been widely separated, and it hardly seems possible—indeed, we regard it as impossible—that the tetanus germs could have been introduced with the vaccine. If the virus was so contaminated, it is morally certain that we would have had a frightful epidemic of tetanus. When one recalls that tetanus may follow after wounds of any character, it is not surprising that vaccination sores should become the seat of inoculation, especially in view of the perfunctory carelessness with which many physicians perform vaccination. More than this, patients themselves are thus taught carelessness. In one of the tetanus cases reported, the inoculation is believed to have been due to the victim's scratching the sore with hands soiled by garden-dirt.

The occurrence of so many cases in Camden possesses some

significance. As is well known, the earth in special localities is more likely to be contaminated with the tetanus bacillus than in others. As a matter of personal experience, we would say that of the four cases of tetanus observed by us, three came from Camden suburbs, while the fourth (from Philadelphia) followed abortion. We believe that investigation of the cases will disclose the possibility of an infection subsequent to the vaccination. At any rate, the cases call for a most searching analysis. In Philadelphia, it is estimated that about 400,000 persons have been recently vaccinated, with one death from tetanus. Camden, a much smaller municipality, has five cases.

We have referred above to the carelessness attendant upon vaccination. We believe that carelessness is a mild term to apply to some of the things we hear concerning it. Thus, we are told that certain vaccinators have performed this little operation on no less than 300 persons in a single day. Think of that! Can it be true? Say the physician works sixteen hours, without a minute's rest. He would vaccinate about one patient every three minutes. To say that good work can be done in such express time is bosh.

To vaccinate properly and safely, the following should be the routine:

1. Scrub the arm thoroughly without antiseptics. The latter interfere with the success of the vaccine.

2. Scarify with an instrument known to be aseptic.

3. Wipe off with aseptic materials the blood and epithelial *débris* produced by the scarification.

4. Apply the virus.

5. Use a shield only to enable the patient to leave the office without waiting for the wound to dry. Instruct him to remove it the following day. Shields are in reality dirty things. They retain secretions and collect dirt.

6. In their place use as a subsequent dressing an aseptic dry compress, which should be changed from time to time according to the indications afforded by other surgical lesions presenting like physical conditions.

7. After the constitutional symptoms of vaccinia have subsided, and if the wound is not progressing favorably, it is permissible to make use of antiseptic dressings, though the latter

had better be avoided, unless the indications for their use are well defined.

8. Instruct patients that vaccination wounds require the same care as that of surgical lesions in general.

THE INSTITUTE MEETS AT CLEVELAND.

IN our news pages this month appears a notice from the president and secretary-elect of the American Institute of Homœopathy announcing that Cleveland has been selected as the place for holding the next annual session of our National organization. With this selection we are, as we believe the profession at large will also be, well pleased. In addition to the reasons assigned for the selection by the officers elect, is also the fact that it has been many years since the Institute met in the territory tributary to Ohio's great metropolis. As a result, it is more than probable that a new record for additions to the Institute membership will be established.

Already the Ohio profession has acted with promptness, and the officers of the Ohio State Society, determined that nothing shall be left undone to make the meeting a success, have arranged that no meeting of their Society shall be held next year, in order that the members thereof shall devote such time as they may be able to spare from their duties to attending the Institute sessions.

The Cleveland profession is to be congratulated in obtaining the Institute as their guest. Ever since the Atlantic City meeting their city has been talked of as a place for meeting; indeed, the Institute did vote to meet there in 1899, but, owing to the completion of the Hahnemann Monument, a change was very properly made to Washington. Those who attend the 1902 meeting of the Institute may feel assured that their interests will be well provided for, and that, from a scientific standpoint, the time spent in attendance will be profitably occupied.

ANOTHER YEAR!

WITH the current number the first year of the *HAHNEMANNIAN* under the present editorial management is brought to a close. The editor takes advantage of this occasion to thank all

who have contributed so generously to the journal's success. The large additions to our subscription list have made it possible to announce that, beginning with the number for January, 1902, the HAHNEMANNIAN MONTHLY will be increased in size to 80 pages monthly instead of 64 pages, as heretofore. This alone will make the journal the largest homœopathic journal published. In addition, the news pages will contain, as heretofore, 12 to 24 pages monthly.

Thanks are due to our collaborators, who have not been mere figure-heads. All have been invaluable as advisers. To Dr. Bigler we are indebted for his services as leading editorial writer, and to Drs. Van Lennep, Goodno and Thomas for their valuable contributions to our pages.

The members of our gleaning staff and our correspondents also come in for praise for the success attending their efforts in making their several departments of interest and of value to our readers.

Our thanks are also due those of our readers who have contributed original articles. To those who have not, we express the wish that they will add their efforts to the success of the journal.

GRANULAR DEGENERATION OF THE ERYTHROCYTE.—(White and Pepper.)—The granular degeneration of the red cell is described as a condition in which fine or coarse granules, having an affinity for basic stains, are found. Their size and shape vary, and they may be scattered equally throughout the cell or form in small clumps. They may also be seen in the nucleated red cell, and have no relation to the nucleus.

As to the diagnostic importance of the granulations, it can be said that there are found in lead-workers not only cases of chronic lead-poisoning, but in cases where there are no subjective symptoms presenting themselves. The amount of the granulations is an index to the severity of the poison.

Experiments on animals show that after feeding a dog on lead acetate the examination of the blood results in the finding of the granulations. These presented themselves within three days after taking the initial dose of the lead salt. The appearance of the granular degeneration in the peripheral blood after one of the writers had taken $7\frac{1}{2}$ grs. of lead acetate shows conclusively the early production of the change in the human blood. Conclusions are: (a) the granules are a constant finding in cases of lead-poisoning, and appear long before the subjective or the objective symptoms present themselves; (b) the granules disappear as convalescence is established; (c) apparently lead does not produce an immunity; (d) the granules may be produced experimentally in dogs; (e) the granules are a true degeneration, and have no relation to nuclear fragmentation.—*American Journal of Medical Sciences*, September, 1901.

GLEANINGS.

THE PREVENTION OF TUBERCULOUS DISEASES IN INFANCY AND CHILDHOOD.—(Knopf.)—The question of transmission is summarized as follows: “Bacillary transmission coming direct through the sperm has been demonstrated experimentally, but clinically the cases are rare. Maternal bacillary transmission seems to take place through the placenta and ovum.” The number of cases coming from these sources is small, and the assumption from the investigations is that the infection comes from without, although there may exist a hereditary predisposition.

The ways of infection are (a) inhalation, (b) ingestion, (c) inoculation. There can be no doubt that many a child has been rendered tuberculous by the taking of food from tuberculous cows, but in more cases the tuberculosis seems to have resulted from the ingestion of pulmonary secretions. The bronchial glands harbor the oldest foci of infection, and a more recent explanation of this is that the infection is from the intestines through the lymphatics to those glands. As to infection by inhalation, the association of the child with a tuberculous parent or friend should be prohibited. The child should also be removed from all danger by reason of coming in contact with the expectoration. The floors, particularly of the nursery, should be kept free from dust, and, of course, from the sputum. Kissing also on the lips is to be avoided. By ingestion is meant the taking of the bacilli into the system in food or some other vehicle; for instance, many of the foods given to children are tasted by tuberculous parents or nurses.

Inoculation is very rare, if we set aside the few cases caused by ritual circumcision. The author has been able to trace twenty authentic cases of local infection caused by the sucking of the wound. Picking of the nose offers a frequent cause of infection by inoculation. The children's nails are capable of carrying infection if they are not kept clean with care; particularly is this the case in eczematous and inflamed conditions of the skin that are attended with itching.

The question of prophylaxis is next brought up as being the most essential factor in the treatment. Great care should be exercised in keeping the child from all persons suffering with the disease. Kissing is to be avoided. The best measure of prophylaxis is the early recognition of the disease. The removal of all obstructions in the respiratory organs, so as to promote normal respiration. The sun- and the air-bath are considered as most beneficial to infants.—*Johns Hopkins Hospital Bulletin*, September, 1901.

William F. Baker, A.M., M.D.

DEATH AFTER CATARACT OPERATION.—Trousseau states that slight as the operation for removing the crystalline lens apparently is, there are undoubtedly a disagreeably large number of cases in which death has either directly or indirectly followed the procedure.

He considers that a fatal issue is at times associated with exhaustion, or

that it may be due to some cause, such as intoxication, from poor excretion, or passive congestion of various organs, notably the lungs. Considering the condition from the clinical side, he closes his consideration of the subject with the following practical suggestions:

1. If an aged patient becomes agitated and delirious after an operation, it should give rise to uneasiness upon the part of the surgeon.

2. When the patient's tongue becomes dry and the quantity of urine voided becomes less, particularly if there is anuria, there is cause for alarm.—Trousseau, Paris, *Annals d'Oculistique*.

William Spencer, M.D.

THE TREATMENT OF CHRONIC BRONCHITIS IN THE AGED.—Campbell insists upon the important part played by toxic factors, notably gout and Bright's disease, in the production of chronic bronchitis; and that intestinal sepsis, liver disorders, alcohol and impure air are causes scarcely less active. In consequence, he advises that in treating chronic bronchitis in those past middle life, the toxicity of the blood should be kept as low as possible. The air breathed should be pure, and nasal breathing insisted upon. The diet should be a bare sufficiency, and alcohol and malt indulged in sparingly, or not at all. Every ounce of superfluous fat should be got rid of. The general health should be maintained at the highest possible level. A vigorous circulation should be maintained. Every precaution should be taken against breathlessness. Breathing exercises should be resorted to in order (among other things) to preserve the mobility of the thorax.—*Brit. Med. Journ.*, October 12, 1901.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF HEMIPLEGIA.—Guthrie believes that hemiplegics are, so far as their paralysis is concerned, too often left to themselves. Doubtless they receive plenty of iodide of potassium, strychnine, and other drugs, but popular and professional pessimism prevents the adoption of other measures. His views are summarized as follows:

1. Neglect and want of treatment aggravate severe, and retard the recovery of mild, cases.

2. The evils to be foreseen and guarded against are articular adhesions, late rigidity, and muscular atrophy.

3. Articular adhesions should be prevented by passive movements of each joint from the very first.

4. Faulty positions of the limbs should be constantly corrected, or they will become chronic.

5. Contractions of muscles should be treated by endeavors to improve the nutrition of their weaker opponents.

6. Massage, passive movements, and, to a less extent, electricity, should be used with this object. These agents not only counteract muscular atrophy from disuse, but probably take the place of normal stimuli and invigorate the neurons.

7. The recovery of mild cases may be often hastened by re-education of movements. Want of re-education frequently prevents recovery.

8. Re-education consists in a combination of passive and active exercises.

9. Movements should be first encouraged in those parts which naturally tend to recover first.

10. Inco-ordination and general weakness of limbs which have not re-

gained power of movement should be treated by exercises and mechanical therapeutics.

11. It is important to find out what the patient can do and to make him do it.

The principles of treatment are the same, no matter what the cause of the hemiplegic condition, whether hæmorrhage or occlusion of cerebral vessels by embolism or thrombosis.—*Lancet*, October 19, 1901.

F. Mortimer Lawrence, M.D.

TREATMENT OF PERFORATING ULCERS OF THE FOOT BY CHIPAULT'S METHOD.—Dr. Péraire, of Paris, in the case of a man of fifty-six years with a perforating ulcer of the foot, which resisted all remedies, and who was suffering at the same time from chronic rheumatism, stretched the internal plantar nerve. The result was successful, for after two and a half years the ulcer, having soon healed, did not recur. The external plantar nerve was also stretched with success in the case of a girl of twenty-two years who had been suffering from a perforating ulcer of the under side of the base of the fourth toe. Two years have passed without a relapse. He operates under cocaine anæsthesia.

Dr. Navarro, of Montevideo, S. A., reports two similar cases. In an alcoholic of thirty-eight years and in a diabetic of fifty-three years the perforating ulcers healed in twelve days in the former and nineteen days in the latter, after stretching the tibial nerves. The former anæsthetic spots became for several months hyperæsthetic; this did not retard healing, however.—*Centralblatt für Chirurgie*, No. 39, 1901.

Frank H. Pritchard, M.D.

HÆMORRHAGES INTO THE SKIN AND MUCOUS MEMBRANE IN A HYSTERIC WOMAN; DEATH FROM APOPLEXY OF THE PANCREAS.—Dr. S. Holth, of Christiania, Norway, reports a very interesting case, which is worthy of study. A hysterical woman who was under observation from her twenty-third to her thirty-first year frequently after emotional excitement would be afflicted with more or less vast cutaneous hæmorrhages; the mucous membrane, and particularly that of the mouth, would be affected with blebs filled with bloody serum, which quickly healed, though twice several large ones in the sublingual region were followed by necrotic ulcers with a grayish base, which were very slow, more than two months, in healing. Certain of these hæmorrhages appeared without any preceding emotional cause, as after slight traumatism, as, for example, after turning a key in a lock which "worked hard." Once the writer traced a cross on her arm, pressing lightly with his forefinger. Twenty-four hours later a bloody cross appeared, which he photographed; this had disappeared about eight days later. The patient related that she had been subject to these hæmorrhages after emotions and traumatism since her twelfth year. Mineral water was tried with some degree of success. Arsenic was given in increasing doses until she was taking 12 mgms. a day. This was continued in this dose for two years. While taking the drug she felt better than ever, and showed no signs of arsenical poisoning; she increased in weight and the hæmorrhages ceased entirely. Several times the author tried in vain to bring out by pressure with his finger the "bloody cross." In the early part of 1900 the patient suddenly died. The necropsy revealed an enormous development of omental and retroperitoneal adipose

tissue, together with two litres of blood in the free peritoneal cavity, which came from an apoplectic area in the tail of the pancreas. All the other internal organs as well as the great blood-vessels were apparently normal. The writer attributed this overdevelopment of fat to the arsenic. The patient was not in the ordinary sense of the word a "bleeder," for hæmorrhage after minor surgical operations, as, for example, drawing a tooth, was insignificant. Neither was she anæmic, diabetic nor albuminuric. Except her hysteria and a local tubercular affection of the foot, she had been free from constitutional and local disease.—*Norsk Magazin for Lægevidenskaben*, No. 6, 1901.

(I once observed a similar case in a man of fifty years, who finally died apoplectic. Before making a diagnosis of hysteria it is well to exclude, above all, diseases of the blood and blood-making organs.)

Frank H. Pritchard, M.D.

MENTHOL IN THE SYMPTOMATIC TREATMENT OF COUGH.—Dr. Saenger, of Magdeburg, speaks highly of inhalations either of menthol, which is evaporated in a spoon over a lamp, in the symptomatic treatment of cough, or one may drop a few drops of a 40–50 per cent. solution on one's hands and hold them up to one's mouth and nose like a chloroform mask, and thus inhale the vapor. This will be found of service if the mucus be not too tenacious. In the latter case one may inject a 10–20 per cent. solution of the drug in olive oil directly into the larynx itself two to four times a day, employing at each time 1 to 2 gms. The patient's relatives may easily do this themselves.—*Muenchener Medicinische Wochenschrift*, No. 41, 1901.

Frank H. Pritchard, M.D.

THE TREATMENT OF HABITUAL CONSTIPATION.—In two recent numbers of the *Medical News* (Oct. 26, Nov. 2, 1901) its subscribers discuss the treatment of habitual constipation. Naturally, regulation of the diet figures largely among the hygienic measures. There is substantial agreement among the contributors that the food should consist largely of those articles which leave a bulky residue after their nutrient constituents have been abstracted by the process of digestion. It is pointed out, however, that bulk is not the only requisite in the intestinal residue; it must be soft as well as bulky. The remnants of a milk diet are bulky enough, but they are apt to take the form of hard masses, upon which the unaided peristaltic movement of the intestine makes little impression. This constitutes the real objection to milk as an article of diet for persons disposed to constipation, and it may be well to remember that the tendency of a milk residue to become agglomerated into seybulous masses may in great measure be reduced by adding salt to the milk. Moreover, the addition of a little salt makes milk more palatable to many persons. By reason, also, of the hard and bulky residue which it is apt to produce, cheese is another article of food that should generally enter but sparingly into the diet of those who are given to constipation. So widely is its constipating effect known that diamond smugglers, it is stated, commonly have recourse to the free ingestion of cheese after they have swallowed the gems. Swiss cheese seems to be free from this constipating effect in a very great measure, and, indeed, it is only comparatively new cheese that appears to be decidedly constipating, the well-ripened product, which is usually eaten but moderately, having no decided action in opposing peristalsis.

The squatting posture is mentioned by some of the contributors as aiding substantially in promoting the process of defecation. There can be little doubt that this is of advantage, but the present conditions of civilized life, especially in urban communities, almost preclude its adoption. It may, therefore, be well to know that its influence may be almost wholly obtained by the simple expedient of crossing one leg over the other while seated in the closet. First one leg and then the other should be brought uppermost. Apparently the effect is that of contraction of the psoas muscles.

F. Mortimer Lawrence, M.D.

THE TREATMENT OF INOPERABLE CANCER.—Cooper (London), after reviewing the various remedies recommended, reaches the following conclusions :

1. That in cases of inoperable sarcoma, more especially the spindle-cell variety, the patient should have the option of Coley's fluid given to him, since a certain number of cases have been cured.

2. That in cases of inoperable cancer of the breast in women of about forty years of age, in whom the menopause has not occurred, the operation of oöphorectomy should be proposed, and this treatment may be combined with thyroid feeding.

3. That in cases of inoperable rodent ulcer, and in the superficial malignant ulceration in other parts, the Roentgen rays give good hope of improvement.

4. That in cases where these other methods are declined or are inapplicable, the internal administration of celandine (*chelidonium majus*) is worthy of trial ; and when the case appears quite hopeless morphia should be pushed without hesitation.

5. Finally, the author suggests that before trying any of these remedies the risk should be fully pointed out to the patient, that the faint hope that most of them afford should not be magnified, and that the discomfort of treatment should be fully discussed ; in fact, the surgeon should not do more than offer the treatment, and leave the person to reject or receive it.—*Lancet*, October 12, 1901.

F. Mortimer Lawrence, M.D.

METHYLENE-BLUE IN CHRONIC OTITIS WITH FOUL-SMELLING DISCHARGES.—Prof. H. Gaudier, of Lille, has found that a 2 per cent. solution of methylene-blue is a very useful local remedy in many cases of chronic otitis, and particularly in those cases in children with foul-smelling discharges which so often resist other antiseptics. After having washed out the auditory canal with a solution of soap and water, the child is instructed to hold its head on one side while fifteen to twenty drops of the solution of methylene-blue is dropped into the ear. With the head held thus for five minutes, the patient, by Valsalva's method, inflates his tympanum three or four times ; this allows the fluid to penetrate into the middle-ear. In nine cases of chronic otitis with perforation, but without the formation of granulations or caries of the ossicles, but accompanied by a very abundant and fetid discharge, a complete cure was obtained in seven in twenty-five to thirty days. One left off treatment, and the other left off treatment on account of mastoid complications. Methylene-blue is both deodorant and antiseptic ; indeed, surpassing the ordinary antiseptics in this condition.—*La Semaine Medicale*, No. 43, 1901. (In

a recent number of this same journal Dr. Hallopeau reported very good results in ozæna from irrigation of the nasal passages with a 2.50 per cent. solution of methylene-blue; this is done at first three times, and later once a day. The inconveniences of this method are that it discolors the nostrils and the upper lip, but it soon brings about deodorization of the nostrils and a cure in three to four weeks.)

Frank H. Pritchard, M.D.

SUPRARENAL GLAND IN THE EPISTAXIS OF HÆMOPHILIA.—Dr. D. McKenzie, in a thirteen-year-old boy who for eighteen days had been suffering from nose-bleed which was incompletely controlled by tamponing, took three ordinary tablets of suprarenal extract, such as are put up by certain pharmacists, and mixed about a gramme of this with one hundred grammes of water. A tuft of cotton was moistened with the clear fluid and pushed into the nostril. The bleeding ceased at once. On removing the tampon it recurred slightly, but it soon stopped after inserting a second one. By this measure the hæmorrhage was easily brought to a standstill.—*Centralblatt fuer Chirurgie*, No. 41, 1901. (Dr. E. A. Schaefer, in the *British Medical Journal*, April 27, 1901, recommends it in cardiac weakness from shock, hæmorrhage, poisoning, etc. He advises a filtered decoction in the proportions of 0.35 : 30. This is injected into a superficial vein, or through the thoracic wall into the heart itself. A decoction in the proportions of 3.0 : 4000.0, locally applied, will cause a violent contraction of the uterus.)

Frank H. Pritchard, M.D.

MALIGNANT GROWTHS OF THE LONG BONES.—Prof. Borelius, of Lund, Sweden, at the fifth meeting of the Scandinavian Surgeons, in Copenhagen, read a paper on this subject. There are several points to be kept in mind. Differentially, one should try to exclude tuberculosis, syphilis and the acute osteomyelitis—not exactly the typical forms, but the less acute ones. With sarcoma of the long bones one may observe high fever and acute symptoms, but it is rare. Volkmann, in 1843, called attention to this feature, and later Trelat, Kocher and Borelius described atypical forms of osteomyelitis and the differential diagnosis of sarcoma. Yet this is often very difficult. A trauma may have preceded in both; the localization is the same, the age of predilection is identical, the clinical course and the external signs are nearly the same. What is to be done then? Then the whole tumor should be split open, and the macroscopical appearances will usually throw light on the growth. If necessary, a bacteriological examination may be done. If one be still uncertain, a little time will clear up the case, for if it be an osteomyelitis an improvement will be noted, and if it be a sarcoma the tumor will increase in size.

As to the prognosis, it is known that some sarcomatous tumors are very malignant and easily undergo metastasis to distant parts, particularly to the lungs; therefore, exarticulation or amputation should be done if possible. As to mortality, the results are quite good. Virchow and Nelaton have dwelt on the fact that certain forms of sarcoma of the long bones, especially of the marrow, the giant-celled sarcomata occupy a special position in pathology, and should be treated conservatively. At the Congress of German Surgeons of 1889, Krause reported on several such cases, where curetting was done with good results; others have merely opened them. There, conservative

treatment is advisable in the giant-celled sarcomata which are well circumscribed, and in another series of cases where the tumor has persisted, been noticed for several years, and, clinically, it is well limited as to its surroundings, and in cases seen very early a resection rather than an amputation should be tried.

Dr. Schaldemose demonstrated specimens from a large number of cases which came under treatment in Prof. Bloch's division of Frederick's Hospital, in Copenhagen. A certain number first came under observation with symptoms pointing to a joint affection. Out of twenty-nine cases, nineteen died, six disappeared, and four are still living—five, three, two and one-half a year after operation, respectively. Dr. Rovsing thought that the whole bone affected should be removed. Differentially, syphilis is of importance. In such cases the X-rays may help one out. For example, in the case of a little boy with a spindle-shaped growth of the left upper arm, whose father was said to have died of a sarcoma of the brain and dura mater, and whose kidneys at the autopsy revealed not only sarcomatous metastases but also syphilitic infarcts, was skiagraphed. Then it was seen that the bone lay intact in a periosteal tumor. The cachectic little fellow, who had been prepared for exarticulation, was given anti-syphilitic treatment, and in fourteen days the growth had wholly disappeared. Another interesting case was that of a man whose left kidney had been extirpated two and a half years previously on account of a renal sarcoma, and about a year ago began to complain of pains in his left elbow. He was treated for gout, by massage and hot douches, and, as he got no better, he consulted the writer, who found limited mobility and roughness of the articular surfaces, but no tumor; while the X-rays demonstrated the lower end of the humerus and the upper portion of the ulna to be totally destroyed by a neoplasm. A resection was done, as the patient refused to allow an amputation. Later, a recurrence appeared in the forearm, and the arm was amputated through the humerus. He thinks it a mistake to be too conservative in treatment, for exarticulation gives an outlook which is unfavorable enough.

A trial incision, if it be not followed by a radical operation, only favors metastasis. Tscherning thought that one cannot always depend on skiagraphy, for often one can only diagnose destruction or thickening, but not to what it is due. Jervell, of Christiania, referred to a case where a sarcoma of the popliteal cavity was diagnosed clinically; but after amputation, anatomically, none could be determined, though later the patient developed ossifying sarcomatous metastases in his lungs and died. He now has under treatment a patient with a giant-celled sarcoma of the right radius, which he has curetted now and then with good results. In operations for these growths he tries to remove the lymph-glands as high up as possible, in order to prevent recurrences. He has observed several cases which, after operation, have remained free from recurrences. Kayser has in one case resected the knee without the neoplasm returning after three years.—*Hospitalstidende*, No. 41, 1901.—(Prof. Karewski, of Berlin, several years ago wrote a pamphlet on the "Surgically Important Syphilomata and their Differential Diagnosis," which is very interesting and instructive. It is often advisable to try antisiphilitic treatment before doing anything radical in many tumors.)

Frank H. Pritchard, M.D.

THE FEVER OF CONVALESCENCE OF TYPHOID FEVER.—Dr. A. Oliari, of Parma, Italy, reports on five cases of fever occurring during convalescence of typhoid, which he observed in the hospital of that city. These little elevations, which rarely exceed one degree, and which are usually due to fatigue or emotion, and are the *fièvre de fatigue* of the French and the *Nachfieber* of the German writers, are by no means so very frequent. His cases were of young persons of 12 to 22 years, of which three were girls and two boys, and who, after having been in convalescence from a typhoid which presented nothing out of the ordinary, who, after a visit from their friends, or having eaten candy, would have a slight chill, with a following fever of 38.3°, 38.2°, or 38.7° C. In the course of several hours the temperature would fall to the normal and convalescence proceed as before. Curiously enough, these cases are not accompanied by the usual changes in the urine which are met with in fever cases; on the contrary, the urine is remarkable for its abundance, its low specific gravity, absence of albumin, and the low proportion of urea which resembles the urine passed after hysteric attacks, especially those which are thermogenic. Therefore, he looks on these cases as of nervous origin, due to irritability of the thermogenic centres, irritated by the long-lasting high temperature of the typhoid itself.—*La Semaine Médicale*, No. 42, 1901.—(Osler, *Practice of Medicine*, p. 13, has paid especial attention to these recrudescences, and they may be the source of great anxiety to the practitioner. Osler notes that the fever may suddenly rise to 102° or 103°, and persist for two to three days, or even longer. But with this there are no constitutional disturbances, no furring of the tongue, nor distention of the abdomen. They are frequently attributed to errors in diet, emotions, constipation, and excitement of any sort, such as seeing friends. Slight elevations of temperature during convalescence are often noticed in very anæmic persons, or in those of highly nervous temperament.)

Frank H. Pritchard, M.D.

LATE SYPHILIS OF THE UTERUS AND ITS SYMPTOMS.—Dr. P. G. Spinelli has made a study of the late forms of the uterus which are due to gummata, as well as vascular and parenchymatous changes in that organ. Syphilitic disease of the uterus is no longer doubted by gynaecologists; he presents seven cases. Three of the women were from 35 to 40 years of age, the other four varied between 52 and 63 years. Syphilitic affections of the uterus may be easily confused with epithelioma and tubercle. The symptom-picture varies according to whether the patient menstruates or not. In the former, pregnancy is liable to be interrupted sooner or later, though it may go on to full term. But, above all, the menses are abundant, and the intermenstrual intervals become shorter. The uterus becomes hypertrophic and uniformly increased in size. The mucosa and appendages present little or no changes. Neither curetting, Apostoli's method nor astringents have the least effect on the hæmorrhages, while anti-syphilitic treatment regulates menstruation and prevents flowing during the intervals.

In women who have passed the menopause there are both metrorrhagia and leucorrhœa. The hæmorrhages do not become abundant, but the patient complains of weakness and looks cachectic. On examination, the cervix and uterus itself, as well as the vaginal rugæ, appear senilely atrophied. All these signs and symptoms are improved by antisyphilitic treatment. The hæmorrhages are caused by syphilitic endarteritis. Hence, in cases of obsti-

nate metrorrhagia. one might do well to think of syphilis as a cause, and to try appropriate medication. Late syphilis of the uterus is more frequent than is generally thought.—*Journal des Praticiens*, No. 42, 1901.—(This localization of syphilis is but little mentioned in most medical works.)

Frank H. Pritchard, M.D.

THE GUMMATOUS MANIFESTATIONS OF LATE HEREDITARY SYPHILIS.—Dr. Diart, in a Paris inaugural thesis, has studied carefully a number of cases of the most frequent, the gummatous manifestations, of late hereditary syphilis. If one remember that after a few symptoms of syphilis during the first few months of life, the disease may remain dormant for ten, twenty, or even thirty years, one recognizes the importance of its study. The gumma of late hereditary syphilis is met with most often between the tenth and twentieth years; in other words, during puberty, and especially in young girls. After the twentieth year it becomes quite rare. It appears at times to originate in an injury, or even a surgical operation. Visceral gummata are much less often noted than those of the skin or subjacent tissues; they more often are diagnosed at the necropsy. The symptoms and methods of development are the same as those of the acquired form. It has been noticed that there are two points of predilection, so as to say: the leg, and particularly its anterior surface, and the cavity of the mouth and pharynx. The outlook for the case depends on the diagnostic ability of the attending physician. Diagnosis is of the greatest importance; if unrecognized, the disease may bring about irreparable destruction of tissues. The diagnosis should be based on the signs of hereditary syphilis, Hutchinson's teeth, leucomata following on the presence of interstitial keratitis, perforations of the ear-drum, linear scars around the mouth, perforations or the scars of former perforations of the soft palate, etc. A careful inquiry as to the health of the other members of the family, —children as well as father and mother,—the existence of former abortions and children often dying in infancy, from the mother's side, while on that of the father the personal history and other signs and symptoms will be of determining value. The German and French writers lay great stress on the father admitting having had syphilis. But in America so many lie about a former history of syphilis that this cannot be insisted upon. Dr. Bartlett has brought that out quite well in his article on "Syphilis of the Nervous System," in Goodno's "System of Medicine." If one be in doubt, one is justified in trying antisymphilitic medication. Locally, one should use Vigo's plaster, and internally about 45 grains (3 gms.) of the iodide a day; if there be a tendency to phagedenic symptoms, the dose may be increased. Hypodermatic injections of either soluble or insoluble salts of mercury may be tried. After the lesion has been cured, one should continue to treat the diathesis with both the iodides of mercury, to which, as are needed, preparations of the phosphates, iron or cod-liver oil may be added.—*Journal des Praticiens*, No. 42, 1901.—(Anyone who is interested in this subject of late hereditary syphilis, and all who practice medicine with any enthusiasm ought to be, should read Dr. Donner's monograph, *Ueber Spätformen von Angeborener Syphilis*, Leipzig, 1896. It is filled with numerous and well-presented cases which are accompanied by a great amount of material gathered from the great syphilographers of the world. It shows what practice is, in the hands of a master physician. Not only that, but it demonstrates how all-important a *diagnosis* is in our daily work.)

Frank H. Pritchard, M.D.

THE SYMPTOMS OF ARTERIO-SCLEROSIS.—Nammack, opening the discussion before the New York State Medical Association, stated that the clinical history of arterio-sclerosis is not the mere story of the past few weeks, but comprises the life history of the patient from his cradle, and often includes that of his fathers also. The symptomatology sometimes makes diagnosis easy and certain, sometimes only presumptive, sometimes impossible. The disease may be extensive and show no external signs whatever. Or it may be distinctly indicated by the hardness and serpentine course of a radial, temporal or other accessible artery. Latent arterio-sclerosis may require for its detection the use of instruments of precision, like the sphygmometer, arteriometer or sphygmograph, for discovery of the increase in the blood pressure. The disease may be latent for a long time, and the symptoms which eventually appear will depend upon the organ which is most affected. Thus, when the aorta suffers, we may have aneurism with its accompanying train of symptoms. When the coronary arteries are implicated, we have heart failure, arrhythmia and stenocardia. Affection of the bronchial and intercostal arteries may give weak respiratory efforts, defective expansion of the chest, emphysema of the lungs. When the process is general (arterio-capillary fibrosis of Gull and Sutton), or when it involves large organs and by increasing blood pressure throws extra work upon the heart, we have hypertrophy of that organ, giving place later to dilatation, and each condition having its characteristic symptomatology.

Sclerosis of the coronary artery announces itself by palpitation after meals, dyspnoea after slight exertion, oppression over the upper part of the sternum, or a sharp pain in the left arm, which is at first relieved by cessation of muscular effort. Later on, attacks of true angina pectoris may set in. Arterio-sclerosis produces nowhere more serious change than in the kidney, leading to sclerosis with its classical signs, to wit: abundant urine of low specific gravity, little albumin, hypertrophied heart. Brain symptoms at first require keen observation on the part of the patient himself. Earlier fatigue, disinclination to effort, especially to the physical effort which has, perhaps, made the man successful in life, irritability, alteration in disposition, headaches in crowded assemblies or in the study, headache after very moderate use of alcohol, tobacco or coffee, all indicate the point where the habits of life must be revised and corrected. The city doctor of forty must consider selling his horse, abandoning his dinner glass of wine, cigar or coffee, and spending more time in the open air. His summer vacation must be longer, and must be spent in some place where he will firmly decline to infringe upon the practice of the local physician. Out-door air expands the arteries better than iodides do.—*Medical Record*, Oct. 26, 1901.

F. Mortimer Lawrence, M.D.

OCULAR COMPLICATIONS OF SMALL-POX.—The physicians of Lyons observed serious ocular complications in an epidemic of 800 cases of small-pox last year, two patients becoming blind.

They found that affections of the cornea and conjunctiva practically represent all of the important complications of this affection.

In all cases of small-pox the conjunctiva is congested, turgescient, and sometimes even œdematous, which makes it appear as if attacked by a violent catarrh. It may be so violent that it gives the impression of a purulent

conjunctivitis. Every now and then the bulbar conjunctiva is attacked with pustules.

The cornea itself is not the seat of variolous pustules. When the cornea is affected it is especially at the time of the desiccation of the pustules and of the different suppurative foci in the body.

The first appearance of the malady is generally at the border of the cornea, with suppurative infiltration at the bottom of the ulcer. The pus corpuscles infiltrate the layer of the cornea, and the grayish-yellow spot extends more and more. Its progress is very like the traumatic ulcer which has been infected by a blennorrhœa of the lachrymal sac. At other times the primary lesion commences at a certain distance from the border, and perhaps owes its development to an erosion of the corneal epithelium. The suppurative lesion grows larger and deeper; at a certain period hypopyon appears, which in general coincides with a participation of the iris in the process. If the disease is not checked, the usual consequences of this type of keratitis become apparent. It was found that instillation of 2 per 1000 solution of methylene blue, several times a day, at the slightest suspicion of disturbance in the eye, was as effective a prophylactic measure as nitrate of silver in ophthalmia neonatorum. In serious cases, they made subconjunctival injections.

Defour recently cured a severe case by subconjunctival injections of a solution of bichloride of mercury, 1:2000.—M. Dufour, *Annales d'Oculistique*.

William Spencer, M.D.

TOPICAL APPLICATIONS FOR VARIOLA AFFECTING THE EYES.—Among simply soothing applications, which perhaps act chiefly by protecting from contact with the air, are cosmoline, albolene, glycerite of starch, etc., and dusting with rice flour or oxide of zinc powder. Aristol powder has been suggested. Mercurial ointment spread on lint is a favorite with some surgeons, and yellow oxide of mercury ointment (gr. j to 3j) may be applied to the lid margins.

Boroglyceride (50 per cent. in glycerin) is soothing and antiseptic and a good protectant.

Ichthyol, in 50 per cent. ointment or wash, has been highly recommended for the prevention of pitting, and may be useful in these cases. It would probably need further dilution for use upon the delicate skin of the lid.

In high-grade, acute inflammations with much swelling, iced cloths may give most relief. The conjunctivitis that usually complicates the affection of the lids aggravates it by the irritation that the discharge produces, and the conjunctival sac should be frequently cleansed by free douching with boric acid wash.—Dr. George C. Harlan.

William Spencer, M.D.

OPHTHALMIA NEONATORUM.—J. E. Weeks, M.D., suggests that the principles involved in the scientific treatment of ophthalmia neonatorum will be appreciated by observing the following facts:

1. The lachrymal fluid is secreted but little during the first month of the life of the child.

2. In infants the conjunctiva of the lids is more severely affected than the conjunctiva of the eyeball.

3. The gonococcus grows more rapidly at a temperature ranging from 96° to 110° F., but grows very slowly at a temperature of 92° F. The same rule applies to the growth of the bacillus of acute contagious conjunctivitis.

The Klebs-Loeffler bacillus and the pneumococcus are not so sensitive.

4. The temperature of the conjunctival sac ranges from 97.5° F. (an approximately normal condition) to 102° F., according to the severity of the inflammatory process affecting the conjunctiva.

5. By making cold applications to the lids the temperature of the conjunctival sac can be reduced from 94° to 88° F., depending on the thickness of the lids.

6. The condition of the infant has a decided bearing on the results of the inflammation of the conjunctiva. A robust, well child is much more likely to recover without permanent injury to the organ of vision.—*New York State Journal of Medicine*.

William Spencer, M.D.

THE WORSTED TRUSS IN INGUINAL HERNIA.—Hubbard (Boston) speaks in favor of the worsted truss in the treatment of inguinal hernia of infants, preferring it to a more elaborate apparatus. He states that if a cure is to result from treatment, it is as likely to follow the wearing of this form as that of any other. A worsted truss is cheap, and when soiled can be changed, washed, and is then ready for use again. It can be worn in a bath, and is less likely to irritate the skin than a spring truss.

Worsted is ordinarily sold in a skein made up of two laps. A lap is sufficient for a truss, and the other half can be kept in reserve to be used when the first is soiled. The method of application is as follows: The child is placed on his back, the half-skein is passed under him and pulled far enough so that the end just reaches the internal ring. The other end is then passed through the loop of this first end, and the hernia is reduced. The bunch of worsted made by the looping of one end through the other is adjusted carefully and firmly over the hernial opening, and the free end then passed under the leg and fastened by a bit of bandage to the part on the back. The truss should fit snugly, and should be worn at night as well as during the day. Whenever it is to be changed, the child should lie down. An undescended testicle, or the presence of a reducible hydrocele, are contra-indications to the application of a truss. An inguinal hernia in a child of two years or under can probably be cured by a truss, whereas in a child over two years the prognosis as to a cure from truss treatment is rather poor. If the truss controls the hernia, it should be worn for six to twelve months, according to the age of the child, the size of the hernia, etc., before it is discarded, for fear of a recurrence.—*Annals of Surgery*, October, 1901.

Gustave A. Van Lennep, M.D.

TREATMENT OF PARALYTIC TALIPES OF THE CALCANEUS TYPE.—Whitman (New York) gives, in addition to tenotomies, forcible correction and the like, undertaken simply to overcome secondary deformity, the following operations: Willett's operation and its modifications, tendon transplantation and arthrodesis, and removal of the astragalus.

Willett's operation consists in dividing the tendo-Achillis, together with the overlying fascia and skin on the back of the ankle, sufficiently to hold the foot at a right angle with the leg, or even in an attitude of plantar flexion. The object is to oppose the resistance of the non-contractile tissues on the back of the leg to the deforming influence of functional use. The procedure is of little service other than restoring temporarily the symmetry of the foot.

When the foot is inclined toward varus or valgus the operation is contra-indicated.

Walsham's suggestion of sawing off the extremity of the os calcis and displacing it further downward has little to recommend it. Tendon transplantation, first performed by Nicoladoni for the relief of this condition, is of little value from a curative standpoint. The objection to it is that the two lateral peronei, which are the ones transplanted into the tendo-Achillis, are utterly inadequate to carry on the function of the strong calf-muscle.

Arthrodesis, or the establishment of a firm right-angled ankylosis at the ankle-joint, is of little value when lateral distortion is present. In such cases the operation must include the sub-astragaloid and medio-tarsal joints also. It is apt to be disappointing if performed in childhood, as growing bone can hardly restrain so marked a tendency toward deformity.

The most effective remedy, in the author's mind, is removal of the astragalus. Sufficient mobility is thus gained to allow of a backward displacement of the foot upon the leg, so that the body weight, instead of falling upon an elongated heel practically in the plane of the flattened calf, is advanced toward the centre of the foot. Thus the adverse leverage which tends toward recurrence of deformity is lessened, and the symmetry of the distorted part in great degree is restored. In addition to this operation, one or all of the procedures that have been described may be indicated as a subsidiary part of the treatment. The incision used for the removal of the astragalus is a long curved one below the external malleolus, from the tendo-Achillis behind to the head of the astragalus in front. The peronei tendons are freed and either divided or displaced backward. The astragalus is then exposed and its removal facilitated by dividing the interosseous ligament and displacing the foot inward. The cartilage is removed from the surfaces of all the adjacent bones. The tendo-Achillis is shortened, and into it are inserted the ends of the two peronei tendons. The wound is then closed, and the foot is displaced backward and held in an attitude of slight plantar flexion by a plaster bandage. Absolute ankylosis is not obtained; the limited motion that remains is desirable, as it lessens the direct strain upon the ankle. The writer prefers to use apparatus to prevent deformity in all cases, although the patients can walk without it, and in time it may be discarded.—*The American Journal of the Medical Sciences*, November, 1901.

Gustave A. Van Lennep, M.D.

DISINFECTION OF CUTTING INSTRUMENTS WITH TINCTURE OF GREEN SOAP.—J. H. Polok recommends that for all instruments that will stand it, boiling in soda solution is the best and safest method of disinfection, but inasmuch as the alcoholic solution of green soap kills staphylococci in fifteen minutes, this method is available for knives, etc. The method that for over half a year has been successfully used in Professor Straub's clinic consists in placing the instruments after use in the soap solution for fifteen minutes, after which they are carefully cleaned. Before operation they are again put in the liquid for the same length of time, are wiped off with sterile gauze and placed in fifty per cent. alcohol or three per cent. boric acid solution. The method is especially useful in office or country practice, where boiling cannot be carried out conveniently, and it gives reliable results.—*Medical Record*, September 28, 1901.

Gustave A. Van Lennep, M.D.

MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND
THERAPEUTICS.

REMEDIES INDICATED IN PARALYSIS OF PERIPHERAL NERVES.—In a paper on “*Lähmungen Peripherer Nerven*” (*Allgemein. Hom. Zeitung*, September 12, 1901), Dr. Kröner gave the following indications for remedies :

Arg. nitr.—Trembling in the affected parts ; rheumatic pains ; sallow complexion ; general weakness ; paresis and rigidity of the affected muscles ; cramps ; decreased sensibility ; increased sensitivity to heat. Clinically, peripheral spinal cord affection ; *alcoholic and post-diphtheritic paralysis*.

Arsen. alb.—Neuritis, followed by atrophy ; violent *burning pains*, especially in afternoon. Useful as an antidote to *chronic lead-poisoning*.

Carbon. sulphur.—Trembling ; great muscular weakness ; *neuralgic affections of upper extremities, with ataxia*.

Cicuta vir.—Cerebro-spinal spasms ; epilepsy ; converging strabismus ; *paralysis of tongue*.

Cocculus.—More central ; sense of deafness ; hyperæsthesia (the characteristic pains of cocculus are fine pains, as if a fine wire charged with electricity were constantly moving in the affected part, usually about a joint. There is also pronounced spinal exhaustion, with aching in back and legs).

Conium.—Acts mainly on cord ; ascending paralysis ; *post-diphtheritic sensory (?) manifestations*.

Cuprum met.—Tremors ; rigidity of joints and trismus, especially in acute neuritis. Affects mainly the flexors.

Curare.—Acts almost exclusively upon the end-plates of motor nerves. *Post-diphtheritic paralyses* (2x dil.). The reflexes are abolished, the opposite from *strychnine*.

Gelsemium.—Cranial nerves, especially the motor oculi.

Hydrocyanic acid.—Paralyses of sudden onset (apoplexia) ; cyanosis ; convulsions.

Lathyrus sativus.—Central paraplegia.

Nux vom.—Hyperæsthesia of all senses ; painful jerking in the affected muscles ; paralysis of eye-muscles and bladder from *spirituous excesses*.

Oleander.—Anæsthesia.

Phosphor.—Neuritis, with fatty degeneration of the nerve fibres ; ataxia from peripheral neuritis or tabes ; trembling ; jerking of muscles ; hyperæsthesia of senses ; *pseudo-hypertrophic muscular paralysis*.

Plumbum.—Radial and facial nerves ; fibrillary twitching of muscles ; hands and feet cold ; conspicuous decrease of perspiration ; *acute poliomyelitis* (anterior) ; rheumatic and neuritic paralyses ; progressive muscular atrophy. (The symptoms of chronic lead-poisoning correspond closely to those of poliomyelitis anterior.)

Secale cornutum.—Posterior columns of gray matter; formication; spasmodic twitching (tetany).

Stannum.—Functional paralysis, with profuse sweating; paresis of lower extremities; knocking knees together.

Zincum.—Cramps; neuralgia and hyperæsthesia (*platina*); myotonia; cannot keep the feet quiet; symptoms worse from stimulants; hysterical paralysis—*valerianate of zinc*.

Causticum affects the bulbar nerves; paresis or paralysis of vocal cords, lips, tongue, eye-muscles. (*Graphites*, facial nerve.)

Rhus tox.—Neuritis of rheumatic origin, with paralyses resulting therefrom; sciatica.

C. Sigmund Raue, M.D.

HEADACHE OF FERRUM PHOS.—A case of intense headache following injury to the head is reported in *Leipziger Populäre Zeitschr. für Hom.*, September 1, 1901. The patient received *arnica* directly after the injury, but the pain in the head did not abate. The pain was relieved by cold application, upon which observation *ferrum phos.* was prescribed with good result.

C. Sigmund Raue, M.D.

PYÆMIA RESULTING FROM PERITONITIS CURED WITH ARSENIC.—Dr. C. von Hartungen (*Leipziger Populäre Zeitschr. für Hom.*, October 1, 1901) reports a case of peritonitis circumscripta following an inflammation in the ileo-cæcal region. The patient, a woman, aged 46 years, multipara, had an attack of peritonitis in April, 1901. July 1st, after a bath, she was taken with a chill, high fever, and intense pain in the right iliac fossa. When Dr. Hartungen saw her, on the 4th of July, there was a tumefaction 4 centimeters above the region of the cæcum, 8 centimeters in length, and 2 centimeters in diameter. *Bell.* and *bryonia* were prescribed. On the night of the 7th of July she was again seized with a chill, which recurred during the following day. The temperature rose to 39.5° C., and remained stationary. *Arsenic*, 15th potency, was prescribed, together with hot fomentations. Improvement set in, and the tumefaction gradually diminished in size. She made a complete recovery.

C. Sigmund Raue, M.D.

GELSEMIUM IN THE TREATMENT OF HYSTERICAL CONDITIONS.—Dr. S. D. Johnson says (*N. A. Jour. of Hom.*) that he has never known of a remedy that would relieve more cases of the hysterical condition than this one. The Gels. patient is very loquacious, or laughing and crying at the same moment. The attack may have come on at a menstrual period, or may have followed the reception of bad news, a sudden shock, as the loss of a member of the family or an immediate friend; the tongue is clean, the throat usually very flabby, and feels very full owing to the paresis and muscular sluggishness. (This latter symptom indicates the drug in follicular angina.) Dr. Johnson thinks that the primary and secondary actions of our remedies are among the most important considerations in the study of the materia medica, and that if we could lead the dominant school to see this point clearly, it would stop their frequent accusation that we are not prescribing homœopathically when we, at times, use material doses. Now, the author apparently believes that he obtains the best results in the above conditions from material doses of the tincture of the Gelsemium. (Languor and malaise are present in the Gelsemium hysteric, and much muscular prostration is also common. Frequent desire to urinate, with profuse pale urine, is another condition. Tiresome

aching at the base of the brain ; and, particularly, frequent "nervous chills," with *trembling* of the entire body.)

O. S. Haines, M.D.

ON BELIEVING EVERYTHING YOU READ.—People who write articles for medical journals, and those who read proof for the same, should remember that there exists a class of readers who believe everything that they read. We notice in the October number of one of our highly esteemed contemporaries the statement that a certain patient received *after each meal* a teaspoonful of glycozone in water, and *three grains of Nux Vomica*. This patient suffered from chronic gastritis, and reported after this prescription that he was better than he had been for four and a half years. Now, as the maximum *daily* dosage of *Nux Vomica* is generally supposed to be but three grains, and of the extract of *Nux Vomica* but two grains, it would, perhaps, be well to inquire of the author what preparation of *Nux* he was in the habit of prescribing. We may be unduly exercised about this matter, but we feel that it would be wise to be very explicit in regard to the dosage and preparation of medicaments recommended in magazine articles.

O. S. Haines, M.D.

THE CARE AND CURE OF SMALLPOX.—Dr. H. M. Bishop, of Los Angeles, Cal., thinks that in some of the direst diseases the medical profession has unfortunately subordinated therapeutics to prophylaxis. He offers smallpox as an example of a disease in which the patient has received scant consideration compared with the strenuous exertions put forth to protect the well. He apparently feels that the prime factor in the deplorable panics that accompany an outbreak of this disease is a lack of confidence upon the part of the profession and the public in the power of medicine to either control or cure the disease. This lack of confidence is not to be wondered at when we read such statements as the following from a recent contributor to the *Cyclopaedia of Medical Sciences*: "There is unquestionably no curative treatment known to medical science for smallpox. The idea of a former generation that medicine could cut short the course of the malady has very properly been abandoned. The treatment must be prescribed with a view simply of palliating the severity of the symptoms." Some members of the homœopathic profession will, we believe, differ from this writer. In contradistinction to the opinion expressed by him might be mentioned the assertion of Dr. Granger, of St. Louis, made some years ago, that under the use of both *Variolin* and *Vaccinin*, the pustules shrink away before arriving at maturity, and that both the severity and duration of the disease is much diminished. Dr. Bishop has also had some experience with the *Variolinum* in the treatment of smallpox, and there is nothing uncertain about his estimate of the value of this medicament. He assures us that if the remedy is given in the commencement and continued, the patient will be convalescent by the time the suppurative stage is due. During an experience extending over a quarter of a century, he has never seen a case whose progress was not arrested by the time the *Variolinum* had been given five days. He mentions some cases in detail that are worth reading, and which seem to substantiate his claims for the remedy. He uses the remedy in the *third trituration* in three to five-grain doses every two hours during the initial fever. It would seem that opportunities are not wanting at the present time to prove decisively whether this remedy will do what is claimed for it. A positive demonstrable fact must surely supersede all negative speculations. But it is

doubtful whether any such bedside test of the remedy will be made. Had these assertions been "*made in Germany*," the case might have been different. —*Pacific Coast Journal of Homoeopathy*, September.

O. S. Haines, M.D.

ON THE FAITH IN THE EFFICACY OF REMEDIES.—There is much truth in what Dr. Conrad Wesselhoeft has to say regarding the skepticism of students, recent graduates and physicians, towards the materia medica. He believes that the students should be made to "see and feel" materia medica as they are made to see and feel, as it were, anatomy and chemistry. First of all, he should see, touch and smell of the actual drugs themselves. These he hardly ever sees; all he knows of them is that they are white pellets or colorless dilutions. He should see and hold in his hand the plants, the minerals and the animal products from which these substances are derived. He should make the tinctures himself. He should grind the triturations instead of being told that a certain substance is to be ground for an hour with sugar and milk. Then he should use his microscope to see just how far he had succeeded in reducing the substance. Then he should proceed to prove the products of his labors upon himself. Such a student will not lament his want of knowledge. Then the student should not be taught the remedies in alphabetical order. He should not be asked to commit to memory pages of symptoms. He should be taught that if he will acquaint himself with the pathogenesis of one member of a natural order or genus, he will already have acquired some rudiments of the other members of that order or genus. He will see that these substances have many points in common, as well as singular and characteristic effects by which they may be easily differentiated. Then, again, the student should not be taught that the application of the homœopathic law of cure is an *easy* matter. He must not think that if he simply finds a remedy whose effects correspond to the case to be treated, that a cure is bound to follow, or his first clinical attempts will be very disappointing and discouraging. He should be instructed in the actual and probable difficulties in the way of realizing quick curative results. He should be told of the imperfections with which pharmacy and the art of proving is still beset. That in the nature of the limitations of the human intellect in its attempts to perfect these sciences, imperfections must still hamper hoped-for results. He must not be discouraged by the absence of startling cures. He must be taught how to recognize each imperfection in order to select from among provings that, and that only, which is likely to be reliable.

By promising too much we sometimes drive the beginner to disappointment, and from homœopathy to the other extreme of polypharmacy and nostrum vending.—*New England Gazette*, October.

O. S. Haines, M.D.

CALCAREA FLUORICA IN NASAL CATARRH.—Dr. Fanning thinks that this is the best remedy that we possess for catarrhal affections of the nasal and frontal bones with foetid discharges, or for actual necrosis with foul odor of dead bone. Catarrh of the head and nose, with stuffy feeling; yellow or greenish-yellow discharge, with sickening odor, which is noticed by the patient himself; discharge may be also in yellow, irregular-shaped lumps. Hawks small lumps from the throat; at times these lumps are very acrid. —*Medical Century*.

O. S. Haines, M.D.

ALOPECIA AREATA.—Dr. Charles A. Gwynn gets most excellent results in this troublesome affection from the repeated application of Spanish fly blisters. The blister is to be applied over the round spot devoid of hair, and the blister paste kept on until a very decided redness of the scalp has been produced. If the blister is repeated, after a little while, in the majority of cases, the hair will make its appearance. In the treatment of alopecia, Dr. Dearborn has found *Phosphorus* often indicated. The next remedy has been *Ferrum phos.*, and the third in order of frequency *Sepia*.—New York State Society Meeting, *Medical Century*.

O. S. Haines, M.D.

THE METHOD OF CHOOSING DRUGS HOMŒOPATHICALLY.—Thomas H. Hayle, M.B.Lond., in an address presented to the Liverpool Branch of the British Homœopathic Society, recognizes two methods of choosing drugs homœopathically: the *repertorial* and the *diagnostic*. He finds fault with the repertorial method, and thinks it stiff, artificial and unscientific. Besides which, it takes a long time, and may, after all, lead one into error. This is the opinion of a goodly number of homœopathic practitioners, and the reasons generally advanced in support of their views are as follows: They say that the *symptoms* which any one drug will set up in different individuals are very various, and differ according to the constitution of the prover. Thus, a drug that causes catarrh of the nose will, in some people, set up a thin, irritating discharge, while in others it will cause a thick, bland discharge. So that the presence of a thin, sanious discharge as the result of *proving* would not contra-indicate the use of the drug in a person who might have a thick, bland discharge, providing the exact nature of the action of the remedy upon the nasal mucous membrane had been recorded and had been found to be similar to the effect of the disease upon that structure or organ. We see no wide difference in this matter, for it is questionable whether the "exact pathological change" would ever be found to be the same in the provers who had at one time a thin, sanious discharge, and at another a thick, bland discharge. The result of noting the exact pathological change or the exact action of the drug at a certain point would simply be that we should have the symptom reading: A certain pathological condition, with a sanious discharge, and at another time another pathological condition, with a thick, bland discharge. Perhaps this would make it easier to select such a remedy in practice, and maybe it would not. Again, the opponents of the repertorial method claim that many of the symptoms recorded in our repertories are trivial and commonplace. Now, if Hahnemann had advised us to base our prescriptions upon trivial and commonplace symptoms, then this argument would stand. But the fact is, he distinctly said that such symptoms were not to be considered as of the first importance in the selection of the *similimum*. In the pathogenesis of every drug, well proven, there are many trivialities, but there are also many symptoms which are at once striking, unusual and peculiar; and it is these that give to each pathogenesis its individuality. So, in every case, well taken, there are to be found many symptoms which are by no means trivial, and which give to that particular case its own individuality. The homœopathist must learn to quickly discover which are the valuable and which are the valueless symptoms.

And still further, it has been argued that if we take many symptoms in a complicated case, and try to work them out in a repertory, we very often, at

the end of a long search, come out with very various medicines for the same patient. Now, we shall not thus come to grief if we have carefully grouped our symptoms before we began the search, selecting the remedy according to the instructions given us in the *Organon*. If we do fail, it will be because our premises were false or because our methods were faulty. There must be better arguments advanced before we shall feel it wise to discard the repertory.

Dr. Hayle thinks better of the *diagnostic* method. In fact, he believes it to be the only scientific method of choosing medicines homœopathically. The action of medicines on the healthy, continues the author, ought to be carefully diagnosed, and in the present day of accurate knowledge this is surely possible. Then, with a perfect knowledge of the exact action of the remedy upon a given point, all that we will have to do will be to carefully diagnose the state of our patient, when we can readily find a suitable medicine for that state without having to hunt through an innumerable list of individual symptoms arranged in a most unscientific and disjointed manner. "In order to carry out properly such a plan of selecting the remedy, we shall find it necessary to have another *materia medica*, a scientific one."

We need a new *materia medica*, but it must be one based upon as careful and painstaking work as that which built up our present *materia medica*. We need re-provings of old drugs, carried as far as may be possible, with scientifically accurate descriptions of the morbid changes produced in the different organs and tissues. We want all the old subjective characteristics, and all the individualizing features of each pathogenesis, either reproduced and their genuineness guaranteed, or else *proven* to be false as guides. The signs of the times are for the accomplishment of this gigantic task. But we had better not talk too much about the trash and chaff and absurdities of our present *materia medica*, for fear the new provings, produced under the fierce light of the twentieth century, may but confirm the old ones.—*Jour. Brit. Hom. Soc.*

O. S. Haines, M.D.

IPECACUANHA.—Dr. E. S. Bailey, in the *Clinique*, refers to the value of this remedy in dysmenorrhœa and in menorrhagia. His treatment of the indications for ipecac. is unique.

Persistent nausea is a characteristic among the ipecac. indications; and by persistent nausea is meant a nausea which is *not* relieved in any way by the vomiting which it has excited. Now, the habit of nausea and vomiting attending each menstrual period is not very infrequent.

In the very young, this persistent nausea is often an attendant upon an enterocolitis; there is a great loss of water and mucus from the intestine, with fermented green mucous stools. Here ipecac. is curative. Again, when the mucous surfaces of the respiratory tract are yielding a constant and sometimes incredible amount of mucus, the patient may have persistent nausea, although there is nothing in the stomach to provoke it. Again ipecac. is indicated. In school-girls, or girls about that age, it is not unusual to find the respiratory, intestinal and reproductive tracts involved at the same time, with large or profuse mucous discharges. As menstruation approaches, the tendency to catarrhal manifestations increases. Then nausea is persistent again. The stools may be of green mucus, or even blood-streaked. The patient has a cough, and the vomiting and coughing, together,

increase the menstrual flow until there is almost a hæmorrhage of bright red blood, which comes in gushes or returns in paroxysms. Ipecac. is again curative.

O. S. Haines, M.D.

DYSMENORRHEA AND ITS CURE.—Dr. J. W. Means' statement that "he is morally certain that there is no drug, without the aid of mechanical measures, that has ever cured a case of dysmenorrhœa," will surely send some old homœopathic warrior's hand to his sword-hilt. So we rush between, with the hastily formed explanation that probably Dr. Means has used the word "drug" in the colloquial sense—that is, he means a narcotic. To claim, however, that no case of dysmenorrhœa has ever been cured by a *homœopathic prescription* would be almost as bad as to say that all cases of dysmenorrhœa will yield to purely mechanical measures. It is the careful discrimination of cases requiring surgical aid from those for whom the similitum is suitable that marks the skillful practitioner. We have often wondered whether many of the little non-essential differences of opinion which arise from time to time among members of our school might not be traceable to the unequal distribution of this discriminating faculty, rather than to the possession, by a few, of a special sort of esoteric knowledge. Dr. Means is a firm believer in the unlimited utility of orificial surgery. He says: "The founder of orificial surgery has done more within the short period of fifteen years, aided by his confrères, to relieve suffering humanity and to overthrow the golden idols of superstition and medical fetichism, than all the medical theorists who have lived within the last century." The treatment of dysmenorrhœa proposed in this paper is as follows:

1. Prepare patient for anæsthetic.
2. During anæsthesia, examine rectum, remove any papillæ or piles, and thoroughly dilate the sphincters.
3. Dilate the vagina with bi-valva speculum, remove papillæ, and then dilate the uterus slowly, but thoroughly. Curette, and flush with hot water.
4. Carefully inspect the urethra and clitoris; introduce a full-size sound into the bladder, and relieve contraction of the hood of the clitoris, if such a condition be present.
5. One month after this operation perform all the above named steps without anæsthetic (save uterine flushing). Once each week the process of dilating and making the necessary medical applications should be performed.

The application of ichthyol one part to three parts glycerine is recommended. The author impresses upon physicians the necessity for being broad and generous enough to absorb the good of all systems. If mechanical treatment is the most successful and the most rational, adopt it. The following little quotation of the author is enlivening: "Medicine has been defined as the art or science of amusing a sick man, and of tampering ingeniously till Nature either kills or cures him."—*Med. Century*.

O. S. Haines, M.D.

USEFUL REMEDIES IN GYNÆCOLOGICAL PRACTICE.—Dr. E. Stillman Bailey read a paper before the Clinical Society of the Hahnemann, Chicago, in which he brought out by comparisons the distinguishing characteristics for belladonna, china, ipecacuanha and hamamelis in gynæcological practice. It is always "time well spent" when one is listening to such papers, and on this particular occasion the discussion seems to have been profitable and full.

Dr. George F. Shears does not think that the *subjective* symptoms are always indicative of the nature of the affection to be treated, and believes that it is necessary to make an objective study of the case as well, in order that we may arrive at a true comprehension of the full extent of the morbid conditions. In this respect the doctor agrees with Hahnemann. Dr. Shears has found *Atropine* useful in ovarian troubles, and differentiates it from belladonna by the fact that in atropine there is *no tenderness* to pressure, although the pains come and go quickly, and are sharp and severe. He thinks that in atropine the pain is due to abnormal conditions in the nerve itself, while in belladonna to the pressure incident to congestion. Dr. Mary E. Hanks confirmed the beneficial action of atropine in all ovarian pains on either side of the body.

Dr. A. L. Blackwood has found that it is necessary to give hamamelis in large doses—ten or even twenty drops (we presume of the tincture)—in order to obtain its full beneficial effects. He recommends the comparison of *China* and *Helonias* for the effects of severe hæmorrhages or loss of fluids. Helonias will produce results, sometimes, when china will not.

Dr. Cobb made the surprising statement that in practice he had not, as yet, been able to confirm the well-known belladonna indications: Suddenness of onset and abrupt closure or cessation of pain. Nor would belladonna relieve the case when the pains were of that character. Dr. Bailey speaks well of the action of hamamelis in ovarian pain, when there are no signs of acute inflammation and but little congestion. The pain is deep-seated, is often a simple ache. This fullness and soreness and aching is seemingly due to *venous* engorgement, and may be relieved as soon as a natural flow comes on.—*Medical Century*, Nov., 1901.

O. S. Haines, M.D.

NOCTURNAL ENURESIS.—There is one remedy that I wish especially to call attention to. I have never seen it recommended for such cases. I think, however, that about one-half the cases will present symptoms calling for *Rhus toxic.*, especially those cases that are twelve years of age or over. When I have a patient who is restless at night, wants to keep warmly covered, and habitually wets the bed every night, I give *Rhus* 200, and usually cure in very short time.—Clinton Enos, M.D., in *The Critique*.

O. S. Haines, M.D.

KEYNOTES OF OUR REMEDIES.—Dr. T. L. Bradford, in his practical little article upon "How to Study the Materia Medica," lays great stress upon the keynotes of our remedies. He means, by these, the peculiar symptoms which are characteristic of the remedy, because they have been verified over and over again. He thinks that with these keynotes as a guide, the minuter symptoms may be also discovered. The important keynote may be a very peculiar one, but whatever it is, it certainly has a reason for being; back of it there is the pathological change producing it. He thinks that Hawkes's "Characteristics or Nash's Leaders" are much better pocket companions for the student than "Billy Baxter's Letters," and regrets that the modern student does less of this sort of studying than the student of years ago. Dr. Bradford is probably correct. The student should very early in his career learn to separate, in the pathogenesis of each drug, those symptoms which are peculiar and characteristic of the remedy from those symptoms which are commonplace. The former should then receive his first attention. They are the individualizing features.—*Hom. Recorder*, October 15th.

O. S. Haines, M.D.

INDEX

TO THE

HAHNEMANNIAN MONTHLY.

VOLUME THIRTY-SIXTH, 1901.

	PAGE		PAGE
A Case of Peliosis Rheumatica with Erythema Exudativum, . . .	764	Acetone and Diacetic Acid in Diabetes, . . .	298
A Food-for-Thought Capsule, . . .	409	Action of Euphthalmin upon the Eye, . . .	239
A New Prognostic Sign in Typhoid, . . .	659	of High and Low Potencies, . . .	601
A New Venom, . . .	260	of Suprarenal Extract, . . .	392
A Plea for Surgical Interference in Gallstone Disease, . . .	669	of Thea upon the Heart, . . .	728
A Plea for the Young Physician, . . .	302	of the Vanadium Salts upon the Liver, . . .	731
A Remarkable Cure with Tuberculin, . . .	599	Acute Articular Rheumatism, Bacteriology of, . . .	494
A Resume of the Therapeutics of Pulsatilla, . . .	105	Dilatation of the Heart in Diphtheria, Influenza, and Rheumatic Fevers, . . .	119
A Salve for Eczema of Children, . . .	190	Malignant Acromegaly, a Case of, . . .	593
A Study of Drug Symptomatology, . . .	612	Nephritis, Treatment of, . . .	593
A Therapeutist Gone Mad, . . .	649	Otitis Media, Treatment, . . .	605
A Valuable Modality in Nux Moschata Headaches, . . .	667	Parenchymatous Nephritis, Adjunct in Treatment of, . . .	725
Abdomen, Penetrating Wounds of, . . .	524	Poliomyelitis Anterior as an Epidemic, . . .	716
Abdominal Operations, Shock in, . . .	448	Adams, T. Louis, M.D. Is the Treatment of Hæmorrhoids by the Injection Method a Rational One? . . .	740
Pain in Typhoid Fever, . . .	389	Adolescence, False Cardiac Hypertrophy of, . . .	125
Operations, Alum Enema After, . . .	720	Alcohol Compresses for Peritonitis, . . .	188
A Case of Acute Malignant Acromegaly, . . .	593	Alopecia Areata, . . .	793
of Melanodermia from Body-Lice, . . .	312	Treatment of, . . .	58
of Primary Epithelioma of the Uvula, . . .	652	Alum Enema after Abdominal Operations, . . .	720
of Argyria, . . .	403	Amputation at Hip-Joint for Sarcoma, . . .	252
of Poisoning by Formalin, . . .	250	Amusements and Science, . . .	387
of Purpura Hæmorrhagica, . . .	602	Anæsthesia of Ear Drum, . . .	596
A Clinical Study of Croupous Pneumonia, . . .	461	Analgesic—Heroin, . . .	540
Study of Diphtheria, . . .	192	An Aggravated Case of Conscientiousness, . . .	667
A Contribution to the Surgery of Multilocular Renal Cyst, . . .	318	Anastomosis of Hollow Viscera Performed by a New Instrument, . . .	317
A Criticism, . . .	580	An Anatomical Deviation of the Kidney and Ureter, . . .	566
A Method of Performing Anastomosis of Hollow Viscera by a New Instrument, . . .	317	Anæmia, with Degenerated Disease of Spinal Cord, . . .	124
A Modern Dogberry, . . .	175	Therapy of, . . .	61
A Nail in the Right Bronchus for two (2) Months, . . .	402	An Epidemic of Poliomyelitis Anterior Acuta, . . .	716
A New Case of Vaginal Cæsarian Section, . . .	527	An Interesting Case of Heredo-Syphilis, . . .	650
Abies Nigra in Bradycardia, . . .	729	Angina Pectoris, Treatment of, . . .	666
Abolition of the Pupillary Reflex and Syphilis, . . .	590		
Abortion, Treatment of, . . .	719		
Abscess of the Cerebellum, . . .	188		
Absorbers of Cataract, . . .	121		
Accidents and Diabetes, . . .	532		
Accommodation, Theories of, . . .	184		

	PAGE		PAGE
Another Year?	775	Bile in the Urine of a Patient Taking Phenacetin.	378
Antistreptococcic Serum in the Fever of Tuberculosis.	55	Biliary Calculi, Representation by X-Rays.	315
Anti-Syphilitic Treatment in Mercurin.	260	Bismuth Poisoning.	377
Antitoxin Treatment of Diphtheria, and Diphtheritic Paralysis.	369	Brawny Inflammatory Infiltration of the Cellular Tissue.	522
and Vaccination-Tetanus.	619	Bright's Disease, Clinical Varieties of.	240
Antidiphtheritic Serotherapy in France.	771	Therapeutics of.	261
Anuria, Hysterical.	307	Bromidrosis of the Axilla.	470
Aortic Regurgitation, with Mitral Insufficiency.	36	Bullard, J. A., M.D. Medical Treatment of Appendicitis.	495
Apis Mellifica.	471	Business Enterprise and the Physician's Dollars.	449
Appendicitis, Clinical Significance of Dulness in.	676	Cactus and Digitalis Compared.	537
Choice of Method of Treatment.	181	Cæsarian Section, Craniotomy and Premature Labor, Indications for.	52
Medical Treatment of.	65	Calcareæ Carbonica.	538
Some of the Complications of.	495	Carb. (200) in Renal Colic.	256
Are Dilated Pupils Indicative of a Pretubercular Stage.	311	Fluorica in Nasal Catarrh.	792
Arsenic, Dangers of the Internal Use of Preparations of.	185	Sulphurica in Empyema.	231
in Pyæmia.	313	Cancer, Cause of.	397
Arterio-Sclerosis, Causes, Clinical Relations and Treatment.	790	of the Stomach, Diagnosis and Treatment.	156
Symptoms of.	422	of the Uterus, Operative Treatment in Russia.	182
Ascites (Chylous), with Pelvic Sarcoma.	785	the Protozoön of.	396
Prognostic Importance of, with Abdominal Tumors.	316	of Uterus, Thiosinamine in Treatment of.	720
Ashcraft, Leon T., A.M., M.D. Therapy of Acute and Chronic Inflammations of the Urethra.	717	Cancers, Inoperable and Treatment of.	718
Diagnosis and Treatment of Chronic Gonorrhœal Prostatitis.	356	Inoperable, Treatment of.	780
Asthma Dyspepticum.	620	Inoperable, and Care of.	733
Atropine in a Case of Ileus in a Hemophilæ.	620	Carbo Veg. in Whooping-Cough.	604
in the Treatment of a Case of Ileus.	125	Carcinoma Uteri, Remote Results of Operations.	530
in Intestinal Obstruction.	591	of Base of Bladder, and Treatment.	319
Maximal Doses of in Intestinal Obstruction.	308	Cardiac Thrombi in Diphtheria.	651
Auto-Intoxication from Renal Insufficiency.	531	Cases, Crategus in Typical.	640
Avena and Arnica as Nervine Tonics.	531	Carduus Marianus in Gallstone Colic.	127
Axilla, Bromidrosis of.	702	Care of the Alimentary Canal Before and After Operation.	697
Bactericidal Effect of Tears.	243	Care and Cure of Small-Pox.	791
Bacteriology of the Normal Nose.	407	of Inoperable Carcinoma.	733
of the Stomach.	470	Carleton, B. G., M.D. Tubercular Cystitis.	133
Baker, W. F., A.M., M.D. Hysterical Anuria.	523	Cataract Absorbers.	121
Baptisia Tinctoria.	184	Extraction, Retarded Cicatrization After.	50
Bartlett, Clarence, M.D. Arterio-Sclerosis.	124	Catarrhal Diseases of Nose and Throat Acting on the General Health.	654
Diagnosis and Treatment of Cancer of Stomach.	36	Cause and Treatment of Profuse Epistaxis.	395
Basedow's Disease without Visible Goitre.	600	of Cancer.	397
Bayley, Weston D., M.D. Dropsy.	422	of Inflammatory Rheumatism.	465
Heat Cases at Hahnemann.	156	Causes of Prelimæteric Hæmorrhages.	462
Apis Mellifica.	400	Ceanothus Virginiana.	196
Beer Yeast for Chronic Constipation.	443	Cerebellum, Abscess of the.	188
Belladonna in Ileus.	508	Cerebral Heredo-Syphilis, A Case of.	650
Bellis Perennis.	679	Cervical Adenitis, Purulent Rhinitis as a Source of Infection of.	118
Bicarbonate of Potash in the Treatment of Grippe.	281	Chase, Theodore L., M.D. A Criticism.	580
	309	Chats with Our Friends.	193
	131	Children's Diseases, Natrum Phos. in.	665
	251	Children, Mental Diseases of.	524

	PAGE		PAGE
Children, Pneumonia in, . . .	178	Croupous Pneumonia, A Clinical Study of, . . .	461
Pyelonephritis in, . . .	179	Cure of Epithelioma by Kali Sulph., . . .	533
Chlorosis, Copper in, . . .	250	of Sea-Sickness, . . .	533
with Optic Neuritis Simulating Tumor of Brain, . . .	315	of Tuberculosis Orchitis with Tuberculin 30, . . .	132
Chorea Cured by Tarentula Cub. 6, Therapeutics of, . . .	192 660	Cures with Silicea and Phosphorus, . . .	730
Christine, G. M., M.D. Preferable Operation for Movable Kidney, . . .	629	Cystitis, Tubercular, . . .	133
Chronic Cystitis in Female, and Local Treatment of, . . .	54	Danger from Milk of Tuberculous Cows, . . .	532
Bronchitis in the Aged, and Treatment, . . .	777	Dangers of the Internal Use of the Preparations of Arsenic, . . .	313
Diarrhœa Cured by Nux Vom. 3, Gonorrheal Prostatitis, Treatment and Diagnosis, . . .	92 620	Peculiar to the Invalid of Exalted Station, . . .	645
Purpura in Arterio-Sclerosis, . . .	400	Deafness, Pilocarpine in, . . .	465
Rheumatism Cured by Kalmia Latifolia, . . .	64	Death After Cataract Operation, . . .	776
Circumscribed Gumma of the Brain, Clinical Features of, . . .	592	Degenerative Disease of the Spinal Cord Associated with Anemia, . . .	124
Cirrhosis of Liver, Operative Treatment in, . . .	463	Detachment of the Retina, Treatment, . . .	466
of the Liver, Treatment, . . .	521	Detection of Incipient Pulmonary Tuberculosis, . . .	530
Cirrhotic Ascites, Operative Treatment of, . . .	114	Diabetes, Acetone and Diacetic Acid in, . . .	298
Clearing of Opacities of the Cornea, Clinic at St. Jacques Hospital, . . .	241 405	Complicating Surgical Measures, . . .	322
Clinical Excerpts of Echinacea, . . .	692	Sodium Salicylate in, . . .	394
Features of Circumscribed Gumma of the Brain, . . .	592	Sudden Changes in Ocular Refraction in, . . .	184
Significance of Dulness in Appendicitis, . . .	181	Diagnosis a Prerequisite to Treatment, . . .	541
Value of the Heart Reflex, . . .	178	and Treatment of Cancer of the Stomach, . . .	156
Varieties of Bright's Disease, . . .	240	and Treatment of Chronic Gonorrheal Prostatitis, . . .	620
Colic, Calcarea Carb. in Renal, . . .	256	of Sub-Diaphragmatic Abscess, . . .	312
Infantile, . . .	185	of Tubal Pregnancy, . . .	310
Coma, Traumatic Diabetic, . . .	251	Diarrhœa, Notes on Morning, . . .	63
Common Sense in Medicine, . . .	268	Dietetic Treatment of Epilepsy, . . .	658
Compulsory Registration of Tuberculosis as a Contagious Disease, . . .	108	Treatment of the Diseases of Children, . . .	503
Concerning Medical Candidates, . . .	238	Difficulties in a Homœopathic Prescription, . . .	363
Congenital Abnormalities of the Cranio-Vertebral Axis, . . .	289	Diffuse Keratitis from Acquired Syphilis, . . .	523
Dislocation of the Hip-Joint, Treatment of, . . .	594	Dilated Pupils as an Indication of a Pretubercular Stage, . . .	185
Nocturnal Incontinence of Urine Cured by Operation, . . .	249	Diphtheria, A Clinical Study of, . . .	502
Stridor of Infants, Causation of, . . .	178	Cardiac Thrombi in, . . .	651
Conjunctivitis Vaccinalis, Cases of, . . .	280	Medical Treatment of, . . .	192
Conservative Treatment of Inflammatory Tumors of Appendages, . . .	723	Patients, Feeding of, . . .	525
Constipation, Beer Yeast in Chronic, Treatment of, . . .	281 779	Diphtheritic Paralysis and Antitoxin, . . .	420
Convulsions, Puerperal, . . .	472	Disappearance of Epiphora after Extirpation of the Tear Sac, . . .	662
Copper in Chlorosis, . . .	250	Disarticulation Through the Hip-Joint, with a Posterior Flap, . . .	252
Corneal Ulcers, Tincture of Iodine in, . . .	595	Discussion on Organotherapy in Diseases of Women, . . .	464
Cortical Localization of Sight and Hearing, . . .	625	Diseases of Children, and Dietetic Treatment, . . .	503
Cough, with Eructation, . . .	728	of the Mammary Gland, and Treatment, . . .	191
Cranio-Vertebral Axis, Congenital Abnormalities of the, . . .	289	Disinfection of the Hand in Obstetrical Practice, . . .	462
Creasote Carbonate in Broncho-Pneumonia and Phthisis, . . .	286	of Cutting Instruments with Tincture of Green Soap, . . .	788
Cratægus in Typical Cardiac Cases, . . .	640	of Typhoid Urines, . . .	180
Crichton, Macpherson, M.D. Pathology in Relation to the Therapy of Specific Urethritis, . . .	93	Distinction of Cardiac Dropsy from that of Advanced Renal Disease, . . .	169
		Dowling, J. W., M.D. Non-Rheu-	

	PAGE		PAGE
matic Causes of Valvular Disease of the Heart, . . .	413	Eye-ball, Perforating Infected Wounds of, and Treatment, . . .	399
Dropsies, Apis Mellifica in, . . .	443	Wounds of, . . .	475
Cardiac and Renal, Differentiated, . . .	169	Eye Diseases, Inflammatory, in New-born Children, . . .	651
Dropsy, . . .	443	Injury from Lightning, . . .	306
Drosera in Whooping-Cough, . . .	604	Symptoms After the Use of Thyroid Preparations, . . .	190
Drug Symptomatology, A Study of, . . .	612		
Dysentery, Geranium in, . . .	540		
Dysmenorrhœa and Its Cure, . . .	795		
		Face and Pupil in Alcoholic Neuritis, . . .	399
Ear-Drum, Anæsthesia of, . . .	596	False Cardiac Hypertrophy of Adolescence, . . .	125
Eclampsia, . . .	656	Feeding of Diphtheria Cases, . . .	525
Preventive Treatment of, . . .	301	Ferrum Phos. and Calcareo Phos. in Fractures, . . .	476
Eclipse Blindness, with Thrombosis of Retinal Artery, . . .	659	Phos. in Headache, . . .	790
Ectopic Gestation, A Study of Some Cases of, . . .	144	Fever, Intermittent, and its Significance, . . .	27
Microscopic Diagnosis of, . . .	325	Fibroids of Uterus, Results of Operations for, . . .	403
Eczema of Children, A Salve for, . . .	190	First Experience with Gold as a Remedy in Disease, . . .	474
Editorial, 39, 108, 171, 233, 302, 378, 449, 515, 585, 645, 705, 767		Foreign Body in the Nose Causing Symptoms Resembling Tubercular Meningitis, . . .	652
Educational Methods in Medical Colleges, . . .	39	Fracture of Humerus, Supra-Condylloid, and Treatment, . . .	126
Effect of Podophyllin upon the Urinary Secretion, . . .	766	Fractures of the Larynx, . . .	283
Election Methods, . . .	383		
Elsewhere vs. Niagara Falls, . . .	116	Gallstone Cases, Treatment of, . . .	411
Emmenagogue, Eumenol, . . .	17	Colic, Carduus Marianus in, . . .	127
Empyema, Calcareo Sulph. in, . . .	231	Disease, Surgical Interference in, . . .	669
Endocarditis, Gonorrhœal Ulceration with Cultivation of Gonococcus, . . .	125	Intestinal Obstruction from, . . .	659
Enlarged Lymphatics, Treatment of, . . .	107	Gastralgia, Treatment of, . . .	232
Prostate, . . .	657	Gastric and Intestinal Diseases, Therapeutics of, . . .	195
Eosinophilia in Trichinosis, . . .	459	Neuroses, . . .	1
Epidermoid Cancer, Treatment by X-Rays, . . .	177	Ulcer, Hæmorrhage in, . . .	668
Epilepsy, Dietetic Treatment of, . . .	658	Indications for Surgical Treatment, . . .	459
Surgical Treatment of, . . .	571	Treatment of, . . .	460
Treatment of, . . .	469	Gatchell, Chas., M.D. Value of the Cardiac Reflex in the Diagnosis and Treatment of Dilatation, . . .	477
Epithelioma, Cure by Kali Sulph., . . .	533	Gelatine, Hypodermatic Use in Hæmorrhage from Stomach, . . .	315
Following the Sting of an Insect, . . .	317	in Controlling Hæmorrhage, . . .	720
Primary, of the Uvula, . . .	652	in Internal Hæmorrhages after Removal of Fibroid of Uterus, . . .	527
Epistaxis, Profuse, Cause and Treatment, . . .	395	Gelsemium in Hysterical Conditions, . . .	790
Erosions of the Cervix, Picric Acid in, . . .	642	Geranium in the Treatment of Dysentery, . . .	540
Eruptions from the Internal Use of Quinine, . . .	250	Giddiness and Vertical Hemipopia, . . .	704
Erysipelas, Treatment by Sulphate of Soda Locally, . . .	522	Glaucoma, Treatment of, . . .	59
Eserin, Action upon the Circulation of the Eye, . . .	121	Gleanings and Medical Abstracts, . . .	177
Etiology of Hepatic Cirrhosis, . . .	519	Gonococcus, Longevity of, . . .	53
of Ophthalmia Neonatorum, . . .	662	Gonorrhœal Cystitis, Treatment by Permanganate, . . .	529
of Yellow Fever, . . .	459	Myositis, . . .	594
Eumenol as an Emmenagogue, . . .	17	Ophthalmia, Remarks upon the Treatment of, . . .	241
Euphorbium, . . .	603	Peritonitis, . . .	183
Euphthalmin, Action upon the Eye, . . .	239	Ulcerative Endocarditis with Cultivation of Gonococcus, . . .	125
Exclusive Soup Diet in Typhoid Fever, . . .	727	Goodno, W. C., M.D. The Gastric Neuroses, . . .	1
External Version in Transverse and Breech Presentations, . . .	247	Antitoxin Treatment of Diphtheria, . . .	369
Extracts of Papers read at the New York State Hom. Society's Meeting, . . .	691	Gouty Catarrh and its Treatment, . . .	320
Extraocular Complications of Sympathetic Ophthalmia, . . .	392	Gramm, Theodore J., M.D. Micro-	
Extra-Uterine Pregnancy, Vaginal Exploratory Incision for, . . .	51		

	PAGE		PAGE
scopic Diagnosis of Ectopic Gestation,	325	Hyperidrosis of the Axilla, Treatment of,	248
Granular Degeneration of the Erythrocyte,	775	Hypertrophied Tonsils,	475
Greer, C. E., M.S., M.D. A Case of Peliosis Rheumatica with Erythema Exudativum,	764	Hypnotism and Hysteria,	243
Grippe, Treatment of,	408	Hypodermic Injection of Gelatine in Serious Hæmorrhage from Stomach,	315
Gummatous Manifestations of Late Hereditary Syphilis,	784	Hysteria and Hypnotism,	243
Hæmatemesis from Varices of Œsophagus or Stomach,	401	Pathology of,	654
Hæmorrhoids, Injection Method of Treatment,	740	Hysterical Anuria,	36
Haines, O. S., M.D. Calcarea Sulph. in Empyema,	231	Sighing, Roaring and Eructating,	189
Have We Kept the Trust Sacred?	259	Idiocy,	121
Hay Fever, Immunization to,	119	Idiopathic Pigmented Sarcoma of the Skin,	401
Suprarenal Gland in,	55	Ileo-Colitis in Children,	695
Treatment of,	685	Ileus. Atropine in a Case of,	591
Headache, Onosmodium Virg. in,	321	Belladonna in,	309
Nux Moschata in,	667	Treated with Atropine,	308
of Ferrum Phos.,	790	Immunization to Hay Fever,	119
Heart, Acute Dilatation in Diphtheria, Influenza and Rheumatic Fever,	119	Importance of the Knowledge of Ear Diseases to the General Practitioner,	186
Affections, Treatment of,	242	Important Factors Influencing Course and Treatment of Pneumonia,	600
and Circulation in Feeble-Minded Children,	459	Incipient Pulmonary Tuberculosis, Detection of,	55
Disease, Sleeplessness and Treatment,	461	Incontinence of Urine, Rhus Arom. in,	412
Reflex, Clinical Value of,	178	Increase in Weight of Infants from Birth,	220
Heat Cases at Hahnemann Hospital,	508	Indications for Cæsarian Section, Craniotomy and Premature Labor,	52
Hæmaturia After Use of Urotropin,	521	for Surgical Treatment of Gastric Ulcer,	459
Hæmorrhage from the Endometrium in Sclerosis of the Uterine Arteries,	598	Infantile Colic,	185
in Gastric Ulcer,	668	Diarrheas, Treatment of,	655
Hæmorrhages. Preclimacteric, Causes of,	462	Inflammations, Pelvic,	18
into Skin and Mucous Membrane in a Hysterical Woman,	778	of Urethra, Therapy of Acute and Chronic,	356
Hemiplegia, Treatment of,	777	Inflammatory Eye Diseases in New-Born Children,	651
Hepar Sulph. in Hay Fever,	407	Injection Method of Treatment in Hæmorrhoids,	740
Hepatic Cirrhosis, Etiology of,	519	Injury of the Eye from Lightning,	306
Inadequacy and Relation to Irregular Gout,	520	Inoperable Cancers, Treatment of,	48
Heresies, Medical,	130	Insomnia, Treatment of,	257
Heroin as an Analgesic,	48	Intermittent Fever, its Significance,	27
High and Low Potencies, and Action of,	601	Internal Hæmorrhages, Treatment of,	56
Homœopathic Aggravations,	732	Intestinal Obstruction from a Gallstone,	659
School, its Necessity for Separate Existence,	32	Obstruction, Surgical Resources in,	206
Therapy and its Relation to Pathology,	85	Pseudo-Lithiasis Due to Drugs,	592
Homœopathy and Medical Science,	233	Intra-Pelvic Operations in Posterior Uterine Displacements,	249
Limitations of,	686	Ipecacuanha,	794
Hot-Air Treatment and the Results,	591	Ipecac and the Violaceæ,	475
How to Avoid Gout,	409	Iris Versicolor in Ophthalmic Megrim,	259
to Cure Whooping-Cough in Ten Days,	408	Irreducible Dorsal Dislocation of the Proximal Phalanx of Index Finger,	316
Howard, E. M., M.D. A Study of Drug Symptomatology,	612	Irrigation in Inflammatory Diseases of Uterus,	123
Hubbard, C. H., M.D. Remedies for Ocular and Circum-Orbital Neuralgias,	227	Is Diagnosis a Prerequisite to Treatment?	541
Hydrotherapy in Pulmonary Tuberculosis,	48		

	PAGE		PAGE
Is the Treatment of Hæmorrhoids by the Injection Method a Rational One?	740	Medical Treatment of Diseases of the Mammary Gland,	191
Jessup, H. I., M.D. Therapeutics of Pulsatilla,	105	Treatment of Tuberculous Peritonitis,	394
Kali Bich. in Keratitis,	410	Medicine in the Nineteenth Century,	171
Permanganate for Spasmodic Croup,	537	Megrim Cured by Anti-Syphilitic Treatment,	260
Sulph. in Cure of Epithelioma,	533	Melanoderma from Body-Lice,	312
Kalmia Latifolia in Chronic Rheumatism,	64	Membranous Angina, Varieties of Microorganisms Producing,	53
Karsner, C. W., M.D. An Address Defending the Bureau of Health in Insisting on Vaccination as a Preventive of Small-Pox,	753	Menorrhagia,	472
Keratitis, Diffuse, from Acquired Syphilis,	523	Mental Diseases of Childhood,	524
Kidney and Ureter, An Anatomical Deviation of,	566	Menthol in Treatment of Cough,	779
Knee-Jerk in Chorea,	394	Mercurius in Prosopalgia,	603
Lachesis in Septic Parotiditis,	297	Method of Choosing Drugs Homœopathically,	793
Laidlaw, G. F., M.D. Urine of Urogenital Tuberculosis,	140	Methylene Blue in Bladder Affections,	470
Larynx, Fractures of the,	283	in Chronic Otitis,	780
Late Syphilis of the Uterus and Its Symptoms,	783	Microorganisms Producing Membranous Angina,	53
Latent Microbic-Endometritis in Pregnancy,	722	Microscopic Diagnosis of Ectopic Gestation,	325
Lawrence, F. Mortimer, M.D. Cardio-Vascular Changes of Chronic Nephritis,	350	Milk of Tuberculous Cows, Danger from,	532
Distinction of Cardiac Dropsy from that of Advanced Renal Disease,	169	Miller, Irving, M.D. Ectopic Gestation,	144
Significance of Intermittent Fever,	27	An Anatomical Deviation of the Kidney and Ureter,	566
The Early Recognition of Pulmonary Tuberculosis,	747	Mills, W. S., M.D. Increase in Weight of Infants,	220
Leucocyte Count in Pleurisy,	47	Misrepresentation,	378
Leucocythemia, Symptoms of,	180	Mitchell, Clifford, M.D. Bile in Urine After Use of Phenacetin,	13
Leucocytosis in Typhoid Perforation,	458	Therapeutics of Bright's Disease,	261
Leucorrhœa,	598	Mohr, Charles, M.D. Relation of Pathology to Homœopathic Therapy,	85
Lewis, F. P., M.D. The Uric Acid States,	197	Morse, B. O., M.D. The Limitations of Homœopathy,	686
Liver, Cirrhosis of and Treatment,	521	Movable Kidney, Preferable Operation for,	629
in Night-Blindness,	402	Kidney, The Corset for,	597
Localization of Sight and Hearing in Cortex,	48	Myoma of Uterine Pregnancy and Labor,	183
Longevity of the Gonococcus,	53	Myositis, Gonorrhœal,	594
Maddux, D. P., M.D. The Care of Inoperable Carcinoma,	733	Nasal Catarrh and its Treatment,	127
Malignant Growths of the Long Bones,	781	Calcarea Fluorica in,	792
Marriage of Tuberculous Subjects,	391	Natrum Mur. in Insanity,	469
Massage in Gynæcology,	247	Phos. in Children's Diseases,	665
Maximal Doses of Atropine in Intestinal Obstruction,	702	Necessity of the Separate Existence of the Homœopathic School,	32
McClelland, J. H., M.D. Existence of the Homœopathic School a Necessity,	32	Neuralgia and Latent Aneurysms of Aorta,	715
Medical Colleges, Educational Methods in,	39	of the Tongue,	664
Heresies,	130	Neuralgias, Remedies in Ocular and Circum-Orbital,	227
Treatment in Diphtheria,	495	Neuroses, Gastric,	1
Treatment of Appendicitis,	192	Neutralization of Toxins by the Digestive Fluids,	313
		New Methods in the Treatment of the Insane,	726
		Niagara Falls vs. Elsewhere,	116
		Nineteenth Century, Medicine in the Normal Nose, Bacteriology of the,	184
		Northrop, H. L., M.D. Congenital Abnormalities of the Cranio-Vertebral Axis,	289

	PAGE		PAGE
Notes on Morning Diarrhœa,	63	Perforation in Typhoid Fever,	122
Nux Moschata in Headaches,	667	Perineal Lacerations, Prevention and Treatment,	561
Vomica in Chronic Diarrhœa,	92	Peritonitis, Alcoholic Compresses in,	31
Obstetrical Interference,	341	Gonorrhœal,	188
Obturator Hernia, with a Report of Two Cases,	758	Pernicious Anæmia, Antiseptic and Serum Treatment of,	397
Occipital Neuralgia, Silicea in,	196	Personal Observations,	482
Occipito-Posterior Positions of the Vertex, Treatment of,	244	Phellandrium Aquaticum and its Use in Consumption,	602
Ocular and Circum-Orbital Neuralgias, Remedies in,	227	Phenacetin Producing Bile in Urine,	13
Complications of Small-Pox,	785	Phosphorus in Scurvy,	194
Diseases, Rhus Tox. in,	667	Picric Acid in Erosions of the Cervix,	642
Disturbances Following the Use of Thyroid Preparations,	457	Acid Poisoning,	644
Refraction, Sudden Changes in Diabetes of,	184	Pilocarpine in Deafness,	50
Tuberculosis and Treatment,	392	Platt, Charles, M.D., Ph.D. Acetone and Diacetic Acid in Diabetes,	298
Odd Remedies in the Treatment of Diseases,	558	Pleurisy, Leucocyte Count in,	47
On Believing Everything You Read,	791	Typhoid,	186
On the Faith in the Efficacy of Remedies,	792	Pneumonia in Children,	178
Onosmodium Virginianum in Headache for Eye-strain,	321	Simulating Appendicitis,	400
Opacities of the Cornea, Clearing of,	241	Treatment of,	181
Operative Treatment of Cancer of the Uterus in Russia,	183	Treatment of, with Brewers' Yeast,	285
Treatment of Pyosalpinx,	719	Podophyllin, Action upon the Urinary Secretion,	776
Ophthalmia Neonatorum,	786	Poisoning by a Belladonna Plaster,	402
Neonatorum, Etiology,	662	by Bismuth,	377
Ophthalmic Megrin, Iris Vers. in,	259	by Formalin,	250
Ophthalmology, Post-Operative Delirium in,	94	by Picric Acid,	644
Optic Nerve, Treatment of Tabetic Atrophy of,	307	from the Use of a Liquid Shoe-Blacking,	660
Neuritis in Chlorosis Simulating Tumor of the Brain,	315	Post-Operative Delirium in Ophthalmology,	49
Oral Sepsis and Pernicious Anæmia,	457	-Scarlatinal Nephritis, Premonitory Stage of,	125
Orbital Heteroplasty by Grafting a Rabbit's Eye into Capsule of Tenon,	661	Powder-Stains, Removal of,	318
Organotherapia in Diseases of Women,	464	Pregnancy and Childbirth Among the Ancient Scandinavians,	636
Otitis, Methylene-Blue in Chronic,	780	Premonitory Stage of Post-Scarlatinal Nephritis,	125
Our Shortcomings,	540	Prevention Better than Cure,	539
Ovarian Opothrapy in Angina Pectoris During Menopause,	457	of Tuberculous Diseases in Childhood,	776
Pancreas, Surgery of,	253	Preventive Treatment of Diphtheria with Antitoxin,	660
Paralysis of Peripheral Nerves, Remedies in,	789	Treatment of Eclampsia,	301
Parenchymatous Nephritis During Course of Tuberculosis,	467	Price, E. C., M.D. Waning of Faith in Drugs,	550
Passiflora in Whooping-Cough,	46	Pritchard, F. H., M.D. Maximal Doses of Atropine in Intestinal Obstruction,	702
Pathological Anatomy of Arcus Senilis,	662	Pregnancy and Childbirth Among the Ancient Scandinavians,	636
Pathology of Idiopia,	654	Some Odd Remedies in the Treatment of Diseases,	558
in Relation to the Therapy of Specific Urethritis,	93	Creasote Carbonate in Broncho-Pneumonic Phthisis,	286
Peliosis Rheumatica with Erythema Exudativum,	764	Procidencia Uteri, Treatment of,	531
Pelvic Inflammations,	18	Prognosis of Aortic Aneurysms,	468
Inflammatory Masses, Removal of,	182	of Ascending Gonorrhœa in Women,	718
Sarcoma with Chylous Ascites,	316	of Tobacco Heart,	395
Pemphigus,	666	Prognostic Importance of Ascites with Abdominal Tumors,	717
Percussion of the Chest, Some Points About,	211	Value of Syphilitic Iritis,	155
		Prosopalgia, Mercurius in,	603
		Prostate, Enlarged,	657

	PAGE		PAGE
Protargol in the Treatment of Metritis,	598	Retina, Detachment of and Treatment,	466
Pruritus Vulvæ, Treatment of,	724	Rheumatism, Inflammatory, and Cause,	465
Psorinum,	604	Rhus Aromatica in Incontinence of Urine,	412
Pulmonary Tuberculosis, Essential Features of Hydrotherapy in,	48	Tox. in Ocular Diseases,	667
Early Recognition of,	747	Richfield Springs and Some Institute Matters,	236
Pulsatilla, Resume of the Therapeutics of,	105	Roberts, George W., M.D. Appendicitis and Treatment,	65
Pulsating Exophthalmos, the Operative Treatment of,	307	Roentgen Rays in the Representation of Biliary Calculi,	315
Purpura Hæmorrhagica, a Case of,	602	Round Worms, Treatment of,	390
Hæmorrhagica, Treatment of by Bichloride,	526	Rumsey, Charles L., M.D. Surgical Resources in Intestinal Obstruction,	206
Purulent Rhinitis of Children as a Source of Infection in Cervical Adenitis,	118	Runnels, O. S., A.M., M.D. Surgical Treatment of Epilepsy,	571
Pyæmia from Peritonitis Cured by Arsenic,	790	Rupture of the Uterus, Treatment of,	183
Pyelonephritis in Children,	179	Sarcoma of Hip-Joint, Amputation for,	252
Pyosalpinx, Operative Treatment,	719	Sarsaparilla (6) in Renal Colic,	64
Quackery,	767	Saturated Solutions of Potassium Iodide,	732
Quinine, Eruptions from the Use of,	250	Searle, W. S., A.M., M.D. Difficulties in a Homœopathic Prescription,	363
Ratanhia, a Study of,	129	Seasickness, Cure and Prevention,	533
Raue, C. Sigmund, M.D. Some Observations upon the Examination of Children,	98	Secondary Action of Certain New Drugs,	535
Dietetic Treatment of Diseases of Infancy and Childhood,	503	Suture of Resected Ulnar Nerve,	315
Raw Meat in Tuberculosis,	248	Sectarianism,	587
Rectal Injections of Cold Water in Typhoid Fever,	717	Separate Existence of the Homœopathic School a Necessity,	32
Registration of Tuberculosis as a Contagious Disease,	108	Septic Parotiditis, Lachesis in,	297
Relations Between Indications for Cesarean Section, Craniotomy and Premature Labor,	52	Sexual Neurasthenia,	699
Relation of Eye-Strain and Pneumogastric Reflexes to Digestive Disorders,	658	Shallcross, I. G., M.D. Apis Melifica,	679
of Pathology to Homœopathic Therapy,	85	Shock in Abdominal Operation,	448
Relative Value of Albumose and Albumin,	120	Shoe-Blacking, Poisoning from,	660
Relief of Pain by Suprarenal Extract,	252	Sighing, Roaring and Eructating,	189
Remarkable Cure of Facial Neuralgia,	725	Silicea in Occipital Neuralgia,	196
Remarks upon Certain Skin Affections,	663	Silicea,	410
upon the Treatment of Gonorrhœal Ophthalmia,	241	in Constipation,	726
Remedies for Ocular and Circum-Orbital Neuralgias,	227	Simplified Method of Examination of Stomach Contents,	56
Indicated in Paralysis of Peripheral Nerves,	789	Skin Diseases, Suppression of,	248
Remote Results of Operations for Carcinoma Uteri,	530	Sleeplessness in Heart Disease, and Treatment,	461
Removal of Pelvic Inflammatory Masses,	182	Small-Pox, Care and Cure of,	791
of Powder-Stains,	318	Smith, Dr. Henry M., The Death of,	305
of the Tonsils,	63	Snader, Edward R., M.D. Prevention of Pulmonary Tuberculosis,	75
Renal Colic, Calcearea Carb. in,	256	Points About Percussion of Chest,	211
Colic Cured by Sarsaparilla 6,	64	Common Sense in Medicine,	268
Re-Proving the Materia Medica,	381	Sodium Salicylate in Diabetes,	394
Resection of the Fat Abdominal Wall in Extreme Obesity,	253	Some Complications of Appendicitis,	311
Retarded Cicatrization of the Cor-		Experimental Results of Tuberculin,	323
		Forms of Complicated Appendicitis,	463
		Observations upon Phosphorus in Scurvy,	194

	PAGE		PAGE
Some Observations upon the Examination of Children,	98	The Fever of Convalescence of Typhoid Fever,	783
Points About Percussion of the Chest,	211	Gastric Neuroses,	1
Quotations, with Comments,	454	Heat Cases at Hahnemann Hospital,	508
Remarks Concerning Silicea,	664	Institute Meeting and Some Institute Matters,	515
Remedies for Otorrhœa,	691	Institute Meets at Cleveland,	774
Soup Diet in Typhoid Fever,	727	Leucocyte Count in Pleurisy,	47
Spasmodic Croup, Kali Permang. in,	537	Limitations of Homœopathy,	686
Wry-Neck and its Treatment,	38	Longevity of the Gonococcus,	53
Spigelia for Symptoms Due to the Presence of Worms,	665	New School of Medicine,	449
Spinal Anæsthesia by Cataphoresis,	389	Non-Rheumatic Causes of Valvular Disease of Heart,	413
State Appropriations for Hospitals,	585	Operative Treatment of Cirrhotic Ascites,	114
Stereoagnosis and Allied Conditions,	390	Operative Treatment of Pulsating Exophthalmos,	307
Stirk, Jas. C., M.D. Therapeutics of Pulsatilla,	105	Philadelphia Medical Journal and Dr. Gould,	112
Stomach Conditions in Early Tuberculosis,	54	Physician's Dollars and Business Enterprise,	44
Contents, Simple Method of Examination,	56	Preferable Operation for Movable Kidney,	629
Study of the Action of Eserin upon the Circulation of the Eye,	121	Present State of Antidiphtheritic Serotherapy in France,	307
Sub-Diaphragmatic Abscess, Diagnosis of,	57	Prevention of Pulmonary Tuberculosis,	75
Sudden Changes in Ocular Refraction in Diabetes,	184	Protozoon of Cancer,	397
Suggestions of the Presence of Nervous Affections,	437	Rational Treatment of Typhoid Fever,	128
Suggestive Value of the Peculiar Features of the Case,	731	Refracting Optician,	393
Sulphate of Soda Solution in Treatment of Erysipelas,	522	Significance of Intermittent Fever,	27
Sulphur, Dosage of,	474	Symptoms of Leucocythemia,	180
Suppression of Skin Diseases,	248	Theories of Accommodation,	184
Supra-Condyloid Fracture of Humerus and Treatment,	126	Therapeutics of Chorea,	62
Suprarenal Extract in Relief of Pain,	252	Training of Sight,	466
Gland in Hay Fever,	55	Uræmia of Elderly Men,	258
Gland in Epistaxis of Hemophilia,	781	Uric Acid Diathesis,	705
Surgery of Multilocular Renal Cyst, of the Pancreas,	318	Uric Acid States,	197
Surgical Interference in Gall-stone Disease,	669	Urine of Uro-Genital Tuberculosis,	140
Resources in Intestinal Obstruction,	206	Waning of Faith in Drugs,	550
Treatment of Epilepsy,	571	Worsted Truss in Inguinal Hernia,	787
Sutherland, J. P., M.D. Is Diagnosis a Prerequisite to Treatment?	541	Thea-Action upon the Heart,	728
Symptoms of Arthritis in Children,	596	Therapeutic Hints,	409
of Arterio-Sclerosis,	785	Indications of Cardio-Vascular Changes of Chronic Nephritis,	350
Syphilitic Iritis, Prognostic Value of,	155	Therapeutics of Bright's Disease, of Catarrhal and Neurotic Gastric and Intestinal Diseases,	261
Tarantula Cubensis,	411	Therapy of Acute and Chronic Inflammations of Urethra,	356
Taraxacum,	322	of Anæmia,	61
Tarentula in Chorea,	192	of Specific Urethritis and its Relation to Pathology,	93
Tears, Bactericidal Effect of,	523	Thermal Carbonated Baths in Gynecology,	50
Terebinthina in Typhoid Fever,	255	Thiosinamine in Cancer of Uterus,	72
Tetanus After Injection of Diphtheria Antitoxin,	309	Thomas, Charles M., M.D. The Treatment of Otitis Media,	605
The Causation of the Congenital Stridor of Infants,	178	Three Dangerous Operations,	529
Care of Inoperable Carcinoma,	733	Thyroid Preparations, Eye Symptoms After the Use of,	190
Clinical Varieties of Bright's Disease,	240	Treatment and Optic Neuritis,	658
Corset for Movable Kidney,	597	Treatment of Diseases of Certain Children,	715
Early Recognition of Pulmonary Tuberculosis,	747	Tincture of Iodine in Corneal Ulcers,	595

	PAGE		PAGE
Tobacco Heart,	732	Treatment of Purpura Hæm. by the	
Prognosis of,	395	Bichloride of Mercury,	526
Tongue, Neuralgia of the,	664	of Round Worms,	393
Tonsils, Hypertrophied,	475	of Rupture of the Uterus,	180
Removal of,	63	of Tabetic Atrophy of the Optic	
Topical Applications for Variola Af-		Nerve,	307
fecting the Eyes,	786	of the Cord in the New-Born,	456
Toxines, Neutralization by the Diges-		of the Insane,	726
tive Fluids,	313	of Talipes Paralytica of the Cal-	
Traumatic Diabetic Coma,	251	caneum Type,	787
Treatment and Prevention of Peri-		of Tubercular Ulcer of the Blad-	
neal Laceration,	561	der,	723
of Abortion,	719	Trepanation in Intracranial Compli-	
of Acute Nephritis,	593	cations of Otitis Media,	311
of Acute Otitis Media,	605	Tubal Pregnancy, Diagnosis of,	310
of Alopecia,	58	Tubercular Cystitis,	133
of Angina Pectoris,	666	Ulcer of the Bladder and Treat-	
of Appendicitis,	65	ment,	723
of Beginning Cataracts by Colly-		Tuberculin in Tuberculous Orchitis,	132
ria and Local Baths of Iodides,	715	Tuberculine, Some Experimental Re-	
of Carcinoma of Base of Blad-		sults of,	323
der,	319	Tuberculosis Fever, Antistrepto-	
of Chronic Bronchitis in the		coccic Serum in,	55
Aged,	777	Ocular, and Treatment,	392
of Chronic Cystitis in Female		Raw Meat in,	248
Locally,	54	Stomach Conditions in Early,	54
of Chronic Exudates in the Pelvis		Tuberculous Peritonitis, Medical	
by Hot Air,	719	Treatment,	394
of Cirrhosis of the Liver,	48	Subjects, Marriage of,	391
of Congenital Dislocation of the		Tuller, John J., M.D. Suggestions	
Hip-Joint,	594	of the Presence of Nervous Affec-	
of Detachment of the Retina,	466	tions to the General Practitioner,	437
of Enlarged Lymphatics,	107	Twentieth Century Cure for a	
of Epidermoid Cancer by the X-		"Cold,"	534
Rays,	177	Two Cases of Uræmic Hemiplegia,	
of Gallstone Cases,	411	with Necropsy,	251
of Gastralgia,	232	Typhoid Fever, Abdominal Pain in,	
of Gastric Ulcer,	460	a New Prognostic Sign in,	659
of Glaucoma,	59	Fever, Complicated with Croup-	
of Gonorrhœal Cystitis by Per-		ous Pneumonia,	721
manganate,	529	Fever, Exclusive Soup Diet in,	727
of Gonorrhœal Ophthalmia,	241	Fever, Perforation in,	122
of Gouty Catarrh,	320	Fever, Rectal Injections of Cold	
of Grip,	408	Water in,	717
of Habitual Constipation,	779	Fever, Terebinthina in,	255
of Hay Fever,	685	Fever, the Rational Treatment	
of Heart Affections,	242	of,	128
of Hemiplegia,	777	Fever, Without Intestinal Le-	
of Hyperidrosis of the Axilla,	248	sions,	240
of Infantile Diarrhœas,	655	Pleurisy,	186
of Inflammatory Diseases of the		Urines, Disinfection of,	180
Uterus by Irrigation,	123	Ulnar Nerve, Secondary Suture of	
of Inoperable Cancers,	48	Resected,	315
of Inoperable Cancer,	780	Uræmia of Elderly Men,	258
of Insomnia,	257	Uræmic Hemiplegia, with Ne-	
of Internal Hæmorrhages,	56	cropsy,	251
of La Grippe,	732	Uric Acid Diathesis,	705
of Metritis with Protargol,	598	Acid States,	197
of Nasal Catarrh,	127	Urine, Bile in, After Taking Phe-	
of Occipito-Posterior Positions of		nacetin,	13
the Vertex,	244	of Uro-Genital Tuberculosis,	140
of Perforating Ulcers of Foot,	778	the Carbohydrates in Diabetes	
of Pneumonia,	181	Insipidus,	389
of Pneumonia with Brewers'		Quantity of, Night and Day,	402
Yeast,	285	Uro-Genital Tuberculosis, Urine in,	
of Pregnancy and Labor Com-		plicated by Myoma of Uterus,	521
of Puerperal Convulsions,	473	Urotropin Producing Hæmaturia,	521
		Urtica Urens,	256
		Use of Picric Acid in Erosions of the	
		Cervix,	642

	PAGE		PAGE
Useful Remedies in Gynæcological Practice,	795	Veratrum Viride in Puerperal Eclampsia,	724
Uterine Displacements, Intra-Pelvic Operation for Posterior,	249	Version and Extraction in Contracted Pelvis,	404
Displacements, Surgical Treatment,	528	Waning of Faith in Drugs,	550
Vaccination and Small-Pox,	708	Weaver, Harry S., M.D. Fractures of Larynx,	282
as a Preventive of Small-Pox,	753	Weight of Infants from Birth, Increase in,	220
Vaginal Cæsarian Section, a New Case of,	527	Whooping-Cough,	46
Exploratory Incision for Extra-Uterine Pregnancy,	51	Carbo Veg. in,	604
Value of Odd Subjective Symptoms, of the Cardiac Reflex in the Diagnosis of Dilatation,	533	Wilcox, DeWitt G., M.D. Pelvic Inflammation,	18
of Veratrum Vir. in Puerperal Eclampsia,	477	Wolcott, Edwin H., M.D. Obstetrical Interference,	341
Valvular Heart Disease. Causes of,	724	Perineal Lacerations,	561
Van Lennep, Wm. B., M.D. A Plea for Surgical Interference in Gallstone Disease,	413	Wood, J. C., A.M., M.D. Personal Observations,	482
Venom, a New,	669	Wounds of the Eyeball,	474
Venous Thrombosis After Typhoid Fever,	260	Penetrating, of the Abdomen,	525
Veratrum Viride,	403	Wry-Neck (Spasmodic), Treatment of,	38
	476	Yale, A. W., M.D. Picric Acid in Erosions of Cervix,	642
		Yellow Fever, Etiology,	459

CONTRIBUTORS AND CORRESPONDENTS.

- Adams, T. Louis, M.D., Philadelphia.
 Arshagouni, John, M.D., New York City.
 Ashcraft, Leon T., A.M., M.D., Philadelphia.
 Bartlett, Clarence, M.D., Philadelphia.
 Bigler, Wm. H., A.M., M.D., Philadelphia.
 Baker, Wm. F., A.M., M.D., Philadelphia.
 Bayley, W. Dod., M.D., Philadelphia.
 Bullard, J. Arthur, M.D., Wilkesbarre, Pa.
 Carleton, Bukk G., M.D., New York City.
 Chase, Theo. L., M.D., Philadelphia.
 Christine, G. Maxwell, M.D., Philadelphia.
 Crowther, Isaac, M.D., Chester, Pa.
 Critchlow, Geo. R., M.D., Buffalo, N. Y.
 Crichton, Macpherson, M.D., Washington, D. C.
 Dowling, Jno. W., M.D., New York City.
 Gatchell, Chas., M.D., Chicago, Ill.
 Goodno, Wm. C., M.D., Philadelphia.
 Greer, C. E., M.S., M.D., Charleston, Ill.
 Gramm, Theo. J., M.D., Philadelphia.
 Haines, O. S., M.D., Philadelphia.
 Howard, E. M., M.D., Camden, N. J.
 Hubbard, C. H., M.D., Chester, Pa.
 Jessup, H. I., M.D., Philadelphia.
 Karsner, Chas. W., M.D., Philadelphia.
 Laidlaw, Geo. F., M.D., New York City.
 Lawrence, F. Mortimer, M.D., Philadelphia.
 Leopold, Herbert P., M.D., Philadelphia.
 Lewis, F. Park, M.D., Buffalo, N. Y.
 Lloyd, Ralph I., M.D., Brooklyn, N. Y.
 Maddux, D. P., M.D., Chester, Pa.
 McClelland, J. H., M.D., Pittsburg, Pa.
 Miller, Irving, M.D., Baltimore, Md.
 Mills, Walter Sands, M.D., New York City.
 Mitchell, Clifford, M.D., Chicago, Ill.
 Mohr, Chas., M.D., Philadelphia.
 Morse, B. O., M.D., Fort Smith, Arkansas.
 Northrop, Herbert L., M.D., Philadelphia.
 Paine, Horace M., M.D., Atlanta, Ga.
 Platt, Chas., M.D., Philadelphia.
 Price, Eldridge C., M.D., Baltimore, Md.
 Pritchard, Frank H., M.D., Monroeville, Ohio.
 Raue, C. Sigmund, M.D., Philadelphia.
 Roberts, Geo. W., M.D., New York City.
 Rumsey, Chas. L., M.D., Baltimore, Md.
 Runnels, O. S., M.D., Indianapolis, Ind.
 Searle, W. S., M.D., Brooklyn, N. Y.
 Shallcross, I. G., M.D., Philadelphia.
 Snader, E. R., M.D., Philadelphia.
 Spencer, Wm., M.D., Philadelphia.
 Stirk, J. C., M.D., Philadelphia.
 Sutherland, J. P., M.D., Boston, Mass.
 Thomas, Chas. M., M.D., Philadelphia.
 Tuller, Jno. J., M.D., Philadelphia.
 Van Lennep, Wm. B., A.M., M.D., Philadelphia.
 Van Lennep, G. A., M.D., Philadelphia.
 Weaver, Harry S., M.D., Philadelphia.
 Wilcox, DeWitt G., M.D., Buffalo, N. Y.
 Winans, Wm. W., M.D., Rochester, N. Y.
 Wolcott, Edwin H., M.D., Rochester, N. Y.
 Wood, J. C., A.M., M.D., Cleveland, Ohio.
 Yale, Arthur W., M.D., Philadelphia.

